The Obstetric Gazette.

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Reports of Societies.

TRANSACTIONS OF THE OBSTETRICAL SOCIETY OF CINCINNATI.

Stated Meeting Thursday, February 8th, 1883.

C. O. WRIGHT, M.D., Vice-President, in the Chair.

ADDRESS OF THE RETIRING PRESIDENT.

The following address of the retiring President Dr. E. B. Stevens, was presented to the Society:

Members of the Society, I desire to congratulate you, that we have now completed our six years of life amid so satisfactory surroundings, and so satisfactory a present history. We commenced our orgnization with a limited number of gentlemen hearty in their taste for this department of medicine: we have year after year, added to our numbers, until now our *constitutional limits* are nearly full, and it will become us as a society to determine in what manner we shall add to our numerical strength—for I need hardly say to you, that in a city of the importance of Cincinnati, there are continually coming to the surface, men and women of such value and such usefulness that as a Society we need their association and their influence and their help. Even now there are many gentlemen of great character and ability in our city that should be interested in our Society, and their association with us would be of mutual advantage, I therefore leave this question of membership for your careful consideration.

The progress and history of the Society has thus far been both pleasant and I may say profitable; I do not in these remarks mean to be regarded as an exponent of any *mutual admiration society*, but I am very sure there are no other orgnizations of like character that have so carefully and so completely worked up a membership so enthusiastic and so devoted to the interest of this particular part of our profession.

It is very evident that the influence of this Society has gone out to the *general* profession of the city and the whole vicinity in a steady quiet way, stimulating inquiry and study in the direction of obstetrics and gynecology, to an extent hitherto unthought of and scarcely deemed worthy of consideration heretofore.

I cannot on an occasion of this kind go into extended remarks as to results; two practical matters may be alluded to, as growing out of your influence as a Society.

First, The Hospital for Women, recently so successfully established by our fellow member Prof. Reamy, may not perhaps be considered as positively the outgrowth of our Society—and yet I very much doubt if such a Hospital as now has its successful working condition in the edge of this city, could have dreamed of like success before the organization and consequent influence that has been excited by the Cincinnati Obstetrical Society. In these remarks I by no means forget the intelligence—experience—and well directed enthusiasm of Dr. Reamy as the projector of his private Hospital. I think we all agree in the confident expectation that this enterprise will prove a blessing and a relief, for a long time to come, to women who are suffering from the accidents and diseases incident to the sex.

Second. The action taken at your last meeting establishing a *Library and Repository* will meet with a hearty approval from hundreds who are not associated with us in fellowship. It may be months and years before such a collection shall assume very great proportions; but the collection will grow indefinitely, and cannot fail to become both attractive and instructive, as an index of the progression, history and development of this department of medicine, and especially of the growth of obstetric medicine in Cincinnati.

Another view of the matter: nearly all our great cities have now established very excellent working Societies kindred to ours; St. Louis has a most excellent Society—indeed one of our best associates, so too Chicago, Philadelphia, New York, and Boston; I believe this enumerates the well established Obstetric and Gynecological Societies of this country, in addition to our own. Boston was the first to step off in this course, and as some of our fellows will remember, this Society endeavored to conduct a Journal especially devoted to this department of work. I hope we shall be able to secure a file of its transactions.

I respectfully suggest that so far as possible we, as a Society endeavor to secure exchanges of Transactions with all active Societies as contributions to our "*Library and Respository*" collection. Probably the great trouble will be that the excellent work of the St. Louis and Chicago Societies and perhaps Societies at other points are buried in the local Journals.

During these few years we have had a great many most excellent con-

tributions to our especial Literature, I cannot call all of these to your attention. Our *American Society* is exactly coexistent with ours as to years and has certainly added most respectably to the experience and information of the profession.

Sometime ago Dr. G. J. Englemann of St. Louis reported a paper to the Missouri State Medical Society, to which I especially desire to call your attention. It is devoted to the dangers which may follow even the most simple operations connected with the uterus or its appendages. In this paper the use of the sound, applications to the cervix, sponge tents, etc., etc.; scarification of the cervix, incisions, use of the curette, etc., etc.; all these indications, and many more are dwelt upon as proper cases for treatment: but the possible dangers are in the surgical treatment of such cases.

In this connection, I desire to enforce the views of Dr. Englemann with a case of my own, which has been under my care during the past year.

In July last, 1882, I was called to see a lady suffering with acute inflammation of the vagina and rectum—muco-purulent discharge from both passages—stools discharged with dysenteric pain and tenesmus. These conditions were relieved by injections of a narcotic, astringent and hot water character, as indications seemed to suggest. The acute conditions being relieved I requested an examination of the vaginal and cervical condition.

I found cervical abrasion, with leuchorrœa, which was treated with alternate applications, as tincture of iodine, carbolic acid, etc. But in a short time I observed—say about Sept. 1st—a thickening of the lip of the uterus, which after a few days developed into a fibro-polypoid growth say about the size of a filbert, but with no pediculated base.

This was removed on the 20th of Sept. Dr. Drake of Lebanon and my student Mr. Smith being my assistants. I dragged the os uteri down to the outlet with the volsellum forceps and scissored off the growth; after this operation the patient appeared entirely comfortable and did well in every respect for some weeks.

About the first of October, say two or three weeks after the operation, I made an examination and found some *slight vegetations*, just about the locality of the operation. At the time of this examination my patient was just approaching her usual catamenial period, and so I deferred any operation procedures until this period should be complete.

Oct. 19th. I find on examination these fungous or vegetation growths have suddenly (now after only two weeks) developed into a *red-pedicle* tumor about the size of a boy's marble.

Oct. 20th. I again removed the small mass, no trouble, passed my finger through the cervical canal and at the request of my valued counsel Dr. Drake scissored some excrescences springing up in the cervical canal,

so that at the conclusion of the operation I regarded the cervical canal perfectly clear of any growth, or vegetation.

After this operation, everthing progressed with perfect comfort to the patient, everything satisfactory to me—for one week. There was *some slight* hemorrhage and some offensive discharge: everthing however seemed doing well for about ten days.

Then suddenly, I had *general peritonitis* set in without any good excuse, no exposure, no exertion, nothing to account for any trouble; of course as I suppose there was some undiscovered traumatic injury, but what it was I am still unable to determine.

Tympanitis and general peritoneal trouble continued for about ten days: under the influence of opium chiefly, the peritoneal inflammation subsided, after which I found a tendency to inflammation of the cellular structure about the uterine body—in a word I had pelvic cellulitis—and yet I found opium successfully controlling even this complication, *until*, just as amidst all these complications, and just as I was congratulating myself on a successful issue, I was discharged from the case and a very clever *Homeopath* employed; then followed a succession of changes. I only have an imperfect history of the subsequent events of the case. My belief was at the time of my dismissal, that the *cellulitis* was coming under the control of treatment—of this I may be mistaken. The case run a rapid course after my discharge; there was pelvic abscess, discharging into the rectum, with an immense amount of purulent discharge. Subsequently an abscess pointed in the femoral region, and on lancing an immense quantity—(say, as reported, a pint of pus) was discharged. This burrowing abscess seemed, *as I learn*, to penetrate the vessels of the femoral region, and suddenly, there was fatal hemorrhage, death taking place in a few minutes.

Now on a survey of the case I cannot see any point of blame; I removed by careful, and perhaps, even, *thorough* operation rapid growth formations; no force was used—my intelligent assistant Dr. Drake thought I had done a very clever operation, and yet, with a clean and successful operation, a pleasant delay of several days, a healthy patient, everything, in a word, doing well, and no *serious* trouble preceding operation, we have suddenly developed a general peritonitis, then pelvic cellulitis, then abscess, then hemorrhage and death. Now there was nothing in the history of this case that would deter me from repeating every step of its treatment so far as I was concerned in its management.

I know the members of this Society are continually performing the most brilliant of the operations in gynecological surgery, and I am equally sure that while we have members ready to undertake the most formidable operations suggested in gynecolgical surgery, yet I also believe we are all—*Conservative*.

I relate my case to reenforce Dr. Englemann in the performance of

professional duty, we must go ahead in what *seems duty*. In the performance of our plainest requirements, we shall perhaps be not only foiled, but our most simple and careful operations be followed by serious if not fatal results.

The whole question of oöphorectomy or "Battey's operation," so called, has had the interested attention of the profession so far, that its character, history and promise is pretty well understood; I have no wish therefore to discuss this point of gynecological progress—but the members of this Society are familiar with the history of this operation, that is, that while we accord priority to our distinguished countryman Dr. Battey, yet at about the same time Hegar extirpated ovaries for the relief of certain constitutional disturbances, and so did Tait, of England; yet neither of these operations were reported until after the published report of Dr. Battey. Hegar and Tait operated in July, 1872, and Battey in August 1872. The operation of Tait however is not precisely that of Battey. Tait's operation consists in the removal of the fallopian tubes, as well as the ovaries, because he believes in that way alone can menstruation be controlled, and also because he regards tubal disease the more important of the pathological factors, as invariably present in chronic ovaritis.

Dr. T. G. Thomas recently reported to the New York Academy of Medicine that he had performed the Tait operation four times and gives the cases in detail. Three of the patients made a good recovery and one died.

Dr. Thomas precedes the report of his cases—with a summary of recent views of Dr. Tait as given in the *British Medical Journal.*

"1. He assumes that the view formerly held that laparotomy and allied operations should be postponed until absolute risk to the life of the patient render them necessary, should be abandoned; and that in the hands of the expert, they are so far from dangerous as to be justifiable even when life is not jeopardized by disease.

2. That the usually accepted doctrine that menstruation depended on ovulation is entirely erroneous.

3. That the ovaries have nothing whatever to do with menstruation, and that this phenomenon is dependent upon the fallopian tubes.

4. That many of the bad cases of abnormal menstruation are relievable only by extirpation of the ovaries and tubes.

5. That in chronic ovarian disease the fallopian tubes are chiefly in fault.

6. That the mortality has been only one in his last thirty-five operations; and that this slight loss of life was susceptible of diminution in the future.

7. That all those cases heretofore regarded as instances of menstrual recurrent pelvic cellulitis or peritonitis are really tubal dropsy and ovarian disease. This last statement was not made in the paper alluded to, but

had been received from Dr. T. A. Emmett, who obtained it from Dr. Tait in a private conversation."

I only find time and room to quote one of the cases of Dr. Thomas, as more satisfactorily indicating the method and propriety of the operation.

"CASE I. A colored woman 30 years of age, the mother of one child eight years old, had suffered from menstruation or recurrent pelvic inflammations, due as has heretofore been supposed to some unknown influence. Her uterus was large, anteverted and gave forth too free a menstrual flow.

Thinking that perhaps profuse menstruation was due to fungoid degeneration of the living membrane, Dr. Thomas carefully curetted the entire mucous surface of the uterus, but to his surprise, removed only a few fungoid growths. An anteversion pessary was introduced and did absolute harm, upon more careful examination, he detected enlarged ovaries, and strongly suspected it was one of those cases in which ovaritis and tubal dropsy were coincident. Further examination convinced him more and more of the truth of this suspicion, and he decided to make an explorating incision, and if the condition existed to perform Tait's operation. The incision was made, one ovary was found cystic, and its Fallopian tube was large and felt very much like a coil of intestine. The tube, the ovary, and the ovarian ligament were ligatured and removed. The same condition existed on the opposite side, and the same procedure was adopted. This together with all the subsequent operations, was performed under the strictest antiseptic precautions, except with regard to the use of the spray, the patient made a prompt recovery. One menstrual period has passed and no sanguineous flow had occurred."

DISCUSSION.

Dr. Thad. A. Reamy, in referring to that part of the address covering minor operations on female pelvic organs, reported three cases with bad results following; one case resulting in death.

CASE I.—Unmarried, aged twenty-eight. Retroversion of uterus with hemorrhage between menstrual periods, leucorrhœa, slight enlargement of the uterus, no abdominal tenderness. Most careful sounding could not determine whether there was a polypus or not. Did the symptoms spoken of depend on the retroversion or might there be a polypus. Retroversion was corrected by introduction of pessary. Bad symptoms continued.

A careful exploration by bimanual manipulations was made, and finding the patient in good condition, no tenderness, two tupelo tents were introduced, a medium sized one first, followed by a smaller one. A Sims' Speculum was used and no force was employed during introduction of tents. In twelve hours after introduction patient had a chill. The temperature rose to 104°, pulse 130, vomiting. The tents were removed and morphia given hypodermically. The symptoms did not subside. A local peritonitis ensued, which was treated by hypodermic injections of morphia and ice poultices.

Finger was introduced into the uterus and a polypus reached, which was broken down and removed without instruments. Temperature and pulse subsided and the case began to clear up. Mentioned the case to show that in some cases there is danger in the simple introduction of a tent, whether there is an old inflammation existing or not.

CASE 2.—Saw at office a married woman, aged thirty-five, residing in an adjacent city. She had been married fourteen years and had borne no children. Menstruation painful. Digital examination made, Sims' uterine probe was introduced, which caused so great pain and shock that she was told to remain in the city. No application was made. There was no difficuty in the introduction of the probe, although the internal os was somewhat small. The cavity of the uterus measured three inches +.

The patient did not obey instructions, but went home on a car thirty miles. On the second day washed, on the third ironed. That night chill, etc. Subsequent symptoms not known. In six weeks died. Fatal result due to the indiscretion of patient.

Speaker does not believe an existing peritonitis as likely to cause an ill result as a cellulitis. Does not think cellulitis exists to the extent that Emmet teaches.

CASE 3.—Tent used for dilating cervix. On day after removal contrary to directions patient went car riding (?). Result, hæmatocele. Ultimately recovered.

Was becoming more and more cautious about office practice. Only makes applications to cervix. Had been in habit of using blunt curette in his office with no accidents following, but most positively had not done so in the last two years; would consider himself guilty of criminal blundering to do so now.

The curette was not used in either of these cases, nor does he ever use it without ordering the patient to bed.

As to the underlying causes, whether it is peritonitis or cellulitis, etc., etc.

In the case where the sound was used there is no question but that the patient had peritonitis with cellulitis, the origin of which was the introduction of the sound and the subsequent imprudence of the patient.

The speaker stated that two of the cases related have occurred within a few months—the third within a year. Of course he had introduced tents—curetted, etc., in hundreds of cases without any untoward results—but he wished to emphasize the fact that with all possible precautions unexpected evils will follow in a certain proportion of cases. He has now abandoned what he had formerly practiced, viz: The use of the curette immediately upon removal of tents. Still more, would he not think of it within a few days after removal of tents.

Dr. Palmer expressed himself as to the precaution necessary to be

taken in gynecological manipulations. Some of these accidents are avoidable; others cannot be foreseen, they arise entirely unexpectedly, and cannot always be avoided. He had as yet had no very serious, or at most any fatal result, following any minor gynecological operation, as sounding the uterus, tenting, curretting, incisions of the cervix, etc., though he realized that he might have, even with every caution. He once encountered a most profuse hæmorrhage while curretting the uterus for a lingering muco-sanguineous discharge after an abortion; and in another instance, witnessed a sharp septicæmia from the retention for several days of a sponge tent which had slipped into the uterine cavity; also, mild attacks of peri-uterine inflammation after intra-uterine medication.

The tendency of accumulating gynecological experiences is to make one more and more cautious; to make one sometimes refrain from doing now that which at one time he regarded as judicious and safe.

A certain minor gynecological operation, as the use of the curette, might be undertaken in a physician's office in numerous instances without a single unpleasant symptom in any. In one or in a certain per cent., a local peri-uterine inflammation may be set up and prove fatal. This accident may not have occurred if the operation had been done at the patient's house and if she had remained quiet for a certain period following. This then is an avoidable accident.

Again, certain patients possess a certain susceptibility to local interference, whether in examination or operation. This susceptibility is not known till tested, and when tested it is too late. This susceptibility may be only a neurosis, or an undetected, insidious peritonitis. Such an accident is unavoidable. It is the commonest thing to find peritoneal adhesions within the pelvis of women dying from non-pelvic causes after the age of 30 or 35 years. A mild pelvic peritonitis, so mild that it has escaped notice, or its symptoms been forgotten, is very frequent.

The frequency of these adhesions prove it, for they are almost as common as similar ones in the pleural cavity of either sex after 30.

Beyond any question the form of accident endangering life under these circumstances is peritonitis, starting within the pelvis, and to which it may be solely confined. Distinct, uncomplicated cellulitis from such causes is rare.

The great safe-guards against these accidents in and after gynecological examinations and operations consists in searching for evidences of a past or latent peri-uterine inflammation. On detection, the simplest examination only should be made. And, *rest* or *quietude* in bed, for from one to three days or more, are often demanded.

If the former is detected and its existence regarded as contra-indicative to manipulations and operations to the extent which it ought, and if the latter were more generally and faithfully observed, we would hear of fewer accidents in gynecological operations.

Retained Placenta—An Inquiry.

Dr. H. Illowy read as follows:

In the winter of 1878 I was requested by a colleague and friend to see a case with him. I saw the patient at noon of that day.

The history of the case was as follows: Mary M., a woman of twenty-five years, tall and thin, very poorly nourished; had suffered previously from chronic diarrhœa; sallow in appearance; living in an attic; was delivered about eight a.m. that day of a dead child at term. The Doctor waited the usual time and then set about delivering the placenta; in making traction the chord was torn off. Then the uterus contracted.

When I saw the patient the uterus was firmly contracted, and it was with great difficulty I could introduce my finger. I attempted to dilate, but not succeeding with little force I desisted, not thinking it safe in the debilitated and broken down condition of the patient to use much force.

I advised stimulants, quinia and washing out the uterus with disinfecting solutions.

Thirty-six hours later the pateint died. The physician in attendance stated from septicæmia.

The question at the time arose in my mind whether it would be better to put the patient under chloroform or other anæsthetic, dilate and extract the placenta.

I could not at the time find any expression upon this point in any of the authorities in my possession, and I ask the question now as I should like to hear the experienced members of our society upon this point.

The question as I view it really contains within itself two questions:

1. Is it better under such circumstances as related (not referring particularly to the general condition and surroundings of the patient) to leave the placenta within the uterus and trust to proper care and attention?

2. Would it be better to chloroform, anæsthetize the patient and extract the placenta?

It is not necessary before such a body of learned and experienced obstetricians to dilate upon the dangers a patient incurs from a retained placenta. Every one of us has experienced the evil train of symptoms that a slight clot formed and retained in the uterus may give rise to, how much more a whole placenta, and how much more if our patient be not in first-class condition and in surroundings not well adapted to ward off infection.

It must, however, not be forgotten that retained placenta does not necessarily always set up mischief. You all well recollect the very interesting case reported here by Prof. Trush, where the placenta was retained

and absorbed. It is not long since a case was reported from Liverpool (if I am not mistaken I saw it in the *N. Y. Medical Record*,) where a placenta had remained in the uterus for a period of over two months, the woman all the time well and about at her household duties, until one day she was suddenly seized with a severe uterine hemorrhage, and to the surprise of the medical attendant, expelled a placenta. During my term of service in the Cincinnati Hospital, there came in two cases of retained placenta that had lasted for a considerable period and in which no other evils followed; they were expelled piecemeal. Those of you gentleman who have had a large experience will be able to recall other cases that have occurred in your practice.

Knowing that it is best to have the placenta removed and all risk to our patient obviated, we come to the second part of our question: "Is it therefore better to anæsthetize our patient thoroughly, dilate the uterus and extract?"

And here again we are confronted with another risk that deserves our serious consideration—an anæsthetic to bring about muscular relaxation and thereby dilatation of the uterus; shall we not expose our patient to the risk of *post partum* hemorrhage? That we run such risk cannot be gainsaid.

In a lecture "On the General Management of the Parturient State,"[1] Prof. Polk, in speaking of the administration of chloroform in the second stage of labor, says: "It should be remembered that in cases in which chloroform has been administered there is always a little more risk of *post partum* hemorrhage." If this be true of the second stage of labor, where the natural physiological excitant of uterine contractions is still present, how much greater risk do we run when the child is already delivered. We must ask ourselves in every case, "Shall we be able to bring about again a rapid and permanent contraction of the uterus?"

From the limited experience that I have had in obstetric practice and knowing how thankful I always feel to Providence when, having delivered a woman, I feel the uterus contracting well and firmly. I certainly should prefer to allow the placenta to remain, more especially with the experience we now have in guarding against septic infection, than to anæsthetize and run the danger of that most dreaded of all acccidents, *post partum* hemorrhage.

Since the above was written, Dr. R. Barnes reports[2] a case wherein his son administered nitrite of amyl for enchatonnement of the placenta by hour-glass contraction. It must be remembered, however, that there is a vast difference between the effects of chloroform and nitrite of amyl —and also between complete relaxation of a completely contracted uterus, and the relaxation of a few wrongly contracted muscular fibres.

1 N. Y. Medical Record, No. 9, 1882.
2 Lancet and Clinic, April 29, 1882.

DISCUSSION.

Dr. Palmer in answer to the inquiry proposed by Dr. Illowy, as to whether it is better in cases of retained placenta, to permit, on the one hand, it to remain until it is either expelled by uterine contraction or slowly disintegrated, or, on the other hand, to remove it even if force is required, and an anæsthetic must be administered to aid in extraction, remarked that he most decidedly favored the latter method of procedure.

Although his inquiry had directly a reference only to cases of retained placenta after delivery at or near term, and more especially when it had been retained several hours before seen, nevertheless, it is not improper to speak of the difference in the management of cases of retained placenta in abortions, as compared with those after premature labor or at term.

As abortions cover the expulsion of the ovum during the first three months of utero-gestation, when at best the placenta is immaturely developed even at the end of that time, and as placenta with parts of the decidua are frequently retained, the abortion being incomplete, the question arises what disposal will be made with these retained products?

If the canal of the uterus is dilated, and the uterine contents detached, they can usually be easily removed, and should be at once. But if the canal is not dilated, the contents attached, and there is no hæmorrhage (and there is not apt to be), is it prudent to permit them to remain, or is it best to proceed with their removal? Just here there is a difference of opinion.

To remove the placenta, implies an artificial dilatation of the cervical canal, and the employment of more or less force in the detachment, an operation sometimes easy of accomplishing; but again, it may be difficult, attended with danger of injuring the uterus, provoking of hæmorrhage and increasing the risk of septicæmia.

The expectant plan, or permitting the uterus to remain undisturbed, is attended with a very slight risk of hæmorrhage, and the danger of septicæmia while the placenta is attached, is inconsiderable. The former, if necessary, is easily controlled by the tampon, till detachment occurs, when all may be removed; the latter, by washing out the vagina with carbolized water, can probably be prevented. Its possible occurrence may make it necessary to empty the uterus.

Under all the circumstances it seems most prudent to take the conservative course—leave the case largely to Nature. Watch for complications, meet them, until some urgency arises by a threatened or developed attack of septicæmia. It is safe to wait for the spontaneous expulsion of the decidua and early placenta, aided, it may be, by the judicious use of the tampon, rather than to forcibly empty the uterus.

But from the third month to the close of the period of utero-gestation,

the dangers of allowing the placenta to remain, whether detached or attached, gradually, but decidedly, increase. These dangers are, persistent uncontrolled hæmorrhage and septicæmia. From either, or both, a life may be sacrificed. They are, of course, greatest near term, because the placenta is largest, the area of the surface to which it is attached largest, and the number and size of the blood vessels ready to bleed and ready to absorb, greatest. The whole uterine organ is most vascular. So far as septicæmia is concerned, a loose placenta is the source of greater danger than one attached, because the latter is still physiologically alive. But hæmorrhage and septicæmia are almost inevitable in either instance, and life is in extreme jeopardy till the uterus is rid of its contents. Under no circumstances, ought the placenta at this time of gestation, retained either from adhesion, or what is infinitely more common, irregular contractions from some cause, be allowed to remain. An immediate delivery of it should be obtained by the physician, in all labors, or within not longer than a half hour. And if from any cause, as neglect or bad management, the placenta has been retained for many hours or some days, the same rule pertains: that is, it is incumbent to obtain a thorough and complete delivery of this organ as soon as practicable. Great exhaustion or collapse from loss of blood, etc., may make it proper to postpone attempts at delivery for a short time; but delay is only for a short time, for the purpose of improving the general condition that the shock of the necessary manipulation may be better borne.

A stimulant and an anæsthetic will doubtless assist both patient and accoucher. With hand in the vagina and fingers rolled into a cone, one or both are slowly and gently insinuated into through the contracted cervical canal, into the upper cavity, to seize hold of the placenta, if loose, or detach it with fingers, if adherent, while by counter pressure, the uterine body is steadied. The work is not to be hurried, and ought to be thorough enough to remove the whole mass. Of course, there are dangers in this operation; shock, hæmorrhage, and inflammation. But any one of these, yes all of them combined, together with the risk of the anæsthetic, are small, indeed, compared with the infinitely greater risks referred to.

Dr. Trush said he was a decided advocate of the early removal of the placenta, he could perceive no advantage and only danger in waiting for spontaneous action of the uterus. So long as the placenta remained in utero the patient was not safe for a moment. He had recently reported a case illustrating, in a very forcible manner, this great peril. After a moderately protracted labor the birth of the child had occurred in the most natural way, and immediately after its expulsion the uterus was hard and well contracted; yet during the brief interval occupied in ligating and severing the cord and removing the child, relaxation and a most appalling hemorrhage took place; ceasing however at once on removal of the placenta. But, even if alarming hemorrhage did not

supervene the patient was presently exposed to another danger, that of septic infection.

Recognizing the existence of these dangers, he was in the habit, at once, after removal of the child, to excite uterine contraction by friction over the fundus. If two or three such contractions did not suffice in dislodging the placenta, he supplemented the natural action of the organ by external compression after the manner of Credé, always taking care not to apply this force upon a flaccid uterus. He had never seen any evil consequences follow this course of procedure and believed it to be a judicious method of managing the so-called third stage of labor. And in the event of failure to deliver the placenta by any other and milder measure, he should not hesitate to attempt its removal by *intra-uterine* manipulations and should make a very determined effort too in this direction, rather than leave the bedside of a patient with a retained placenta. In a case like that of Dr. Illowy he should endeavor as speedily as possible to force an entrance into the uterine cavity, employing for this purpose anæsthetics—ether—if required and without unnecessary delay remove or at least attempt to remove the retained after birth. He would, of course, first administer stimulants to revive the patient, if greatly prostrated, before instituting operative procedures.

Delayed Labor due to Shortened Cord.

Dr. C. O. Wright reported the following: Was called to see Mrs. B. primipara, Feburary, 3rd 1883. Found second stage well advanced. Pains regular, and strong. Repeated examinations did not show any advance of the vertex. Patient becoming somewhat prostrated, and an examination revealing a capacious pelvis, a fully dilated os, and a comparatively small head, instruments were applied and the child with placenta delivered. The cord was wrapped once around left wrist of child, and was but six inches in length in its entirety. Showing conclusively to my mind, that the delay in the delivery was the result of the shortened cord. Child and mother did well. It was somewhat unique to me, never before having seen anything similar.

Treatment of Goitre.—Dr. Grunmach, of Berlin, has employed an arsenical injection into the parenchyma of the enlarged thyroid body in more than one hundred cases. The injection consisted of one part liquor potassæ arsenitas to three of water. This solution was made use of two or three times a week. The average total number of sittings was ten to fifteen. The evil effects sometimes seen after the use of iodine never once occurred with this arsenical preparation. The effect was to diminish the tumor, and to remove the obstruction to the breathing supposed to be due to the pressure on the trachea. The general health of the anæmic patients was much improved.—*Medical Times and Gazette.*

OBSTETRICAL SOCIETY OF PHILADELPHIA.

Stated Meeting, Thursday, March 1st, 1883.

The President, R. A. Cleemann, M.D., in the Chair.

Dr. W. Goodell presented the specimens and reported a case of

Double Enucleation of Uterine Fibroids.

Mrs. B., a Hebrew lady, aged 38 and the mother of five children, the youngest five years old, began early in 1880 to have menorrhagia and difficult micturition. Later, her physician, Dr. A. H. McAdam discovered a uterine fibroid. In January, 1881, Dr. Goodell was called in to see her. He confirmed the diagnosis and found a fibroid in the anterior wall of the womb, bulging out the anterior lip of the cervix, which was greatly hypertrophied, but not at all enlarging the os. The sound gave a measurement of six inches. As all remedial measures wholly failed, he admitted her into his private hospital, and on February 6th cut into the tumor by means of Adams's Subcutaneous Saw, and by enucleation removed most of it. A month later the fragment left behind descended low enough to be removed without difficulty. The tumor weighed not quite two pounds. At the time of this last operation a small fibroid was discovered in the posterior wall of the womb, but it was too high up to be attached. Her convalescence was prompt and her monthly flux became natural. On October 6th the sound gave a measurement of only three inches and she felt well. But in the following March she again sought his advice for a return of the menorrhagia. A fibroid was now bulging out the posterior lip of the cervix but not expanding the os. The uterine cavity measured five inches. As all remedies again failed, enucleation was once more proposed, and on February 28, 1883, the operation was performed for the second time. The posterior lip of the cervix was cut open by the saw without invading the uterine cavity, and after an hour's hard work a tumor weighing one and a half pounds was taken away in fragments. Several very beautiful and perfect fibroids as large as a pigeon's egg were also removed. They were attached to the capsule of the mother tumor merely by loose connective tissue. About a pint of blood was lost during the operation, but after the removal of the tumor the hemorrhage ceased, and the cavity left behind was not tamponed. The patient is doing very well, although the shock was somewhat profound.

In commenting upon this case, Dr. Goodell remarked that the to and fro linear movement of the saw made it a very efficient instrument for working in narrow channels, and that it had the further merit of lessening the amount of hemorrhage. He now used no other instrument for incising the capsule of fibroid tumors. The history of this unique case

had somewhat shaken his confidence in the operation of enucleation, because since the womb is affected usually with multiple fibroids, some one of these must invariably be left behind and a second operation may become useful. He believed that in these cases oöphorectomy, as a safer and more sure remedy, had a future before it. He had, in fact, performed the operation four days ago on a lady who was so feeble from prolonged hemorrhage that he did not dare to remove the fibroid by enucleation, which is a more prolonged operation and attended by a greater loss of blood. She was doing very well indeed. For the same reason, not daring to enucleate, he had early last year removed both ovaries for a bleeding fibroid, but after a remission of several months the hemorrhage returned, and he will probably have to perform enucleation or hysterectomy.

DISCUSSION.

Dr. B. F. Baer inquired if the case in which hemorrhage returned after oöphorectomy was not of the sub-mucous variety. Ought not the operation to be limited to the instersticial and sub-peritoneal varieties, where enucleation is not possible? In one case, reported by Dr. Byford, of Chicago, a uterine (sub-mucous) fibroid went on increasing and hemorrhage continued after oöphorectomy.

Dr. Goodell from *apriori* reasoning would expect less favorable results in submucous tumors as they are more like polypi in their characters and would be more likely to continue to bleed. The case referred to in which oöphorectomy had failed was of the submucous type and could have been removed by division of the mucous membrane and enucleation had the patient's condition permitted it.

Dr. B. F. Baer narrated the history of a case in which

Induction of Premature Labor for the Relief of Suppression of Urine

Was considered necessary. The case occurred in the practice of Drs. Marcy and Mecray, of Cape May, N. J. About the sixth month of pregnancy a general œdema was noticed and the urine contained albumen and a few casts. The amount of urine passed diminished rapidly, while the proportion of albumen increased, and the patient became weak and anemic. Every means was tried to increase the quantity of urine, but without avail. Among the remedies used were a wide range of diuretics and hydragogue cathartics with Basham's mixture. A sudden suppression of urine occurred at eight months, and but four ounces were passed in forty-eight hours, this became solid when heated; headaches and spots before the eyes were now added to the other symptoms, a grumous discharge from the uterus had been noticed for a week, and convulsions seemed threatening. Dr. Baer was called in consultation, and he agreed with them as to the advisability of inducing premature labor.

A No. 9 flexible catheter was warmed and softened and was after great difficulty introduced between the membranes and the anterior wall of the uterus. The cervix uteri had been lacerated in a previous labor and was hard and small. Pains of a natural character followed immediately upon the introduction of the catheter. After some hours the pulse became weak and the patient faint, the os was but slighly opened, and it was considered advisable to administer stimulants, use Barnes' dilators and the Hodge forceps; a dead child was speedily extracted. The latter had been alive in the morning. Four hours after delivery urine was secreted, and in two days the albumen had entirely disappeared. The patient recovered.

Dr. .D F. Willard reported a case of

INDUCED PREMATURE LABOR NECESSITATED BY GREAT ŒDEMA OF THE LABIA MINORA.

The patient, probably over forty years of age, had been married about one year and was pregnant with her first child. She suffered from headache, her feet and eyelids were swollen, and her urine showed one-sixth albumen and contained casts and blood capsules. Basham's mixture, diuretics of every kind, diaphoretics, hot-air baths, hydragogue cathartics and tonics were used without a satisfactory result. Digitalis infusion and jaborandi alone gave a very temporary relief. The patient, soon after her first visit, called attention to the condition of the labia minora, which were found to be enormously swollen, shining, tense and pitting on pressure. The urine amounted to from fifteen to thirty ounces per day, and steadily decreased in quantity. The edema of other portions of the body decreased under the use of digitalis, but that of the labia increased. The patient could lie only upon her back, with the knees drawn up and as widely extended as possible; the pain was great and constant. Lancet punctures were made with temporary relief. The patient was steadily failing, her pulse was 150 per minute. An erysipelatous blush made its appearance and rapidly spead to the abdomen and thighs. Premature extraction of the child offered the only chance and was at once performed. Gestation had reached eight months. It was a difficult task, as the labia were five inches in depth. Barnes' dilators and the Hodge forceps were used and delivery accomplished in two hours. The child was dead and the mother died three hours later.

W. H. H. GYTHENS, Secretary.

IMMENSE TONGUE.—Dr. Pèrin reports a healthy infant born with an immense tongue which protruding from the mouth extended below the chin. The child grew and the tongue decreased in volume, until at six years its size was nearly normal. Under the influence of an acute affection its proportions again increased, when part of it was removed by the écraseur.

M. STANTON.

PROCEEDINGS OF THE COLLEGE OF PHYSICIANS OF PHILADELPHIA.

Session of March 7th, 1883.

Dr. Walter F. Atlee, reported as follows

The History of a Case of Abdominal Cystic Tumor.

In June, 1874, I removed, by laparotomy, in the St. Luke Hospital, Bethlehem, a multilocular cyst from Mrs. DeM———. The history of the case was given by Dr. Stout to the Board of Trustrees, and published in the second Annual Report. The whole mass removed at the operation weighed seventy-eight and a half pounds. The lobes and lobules composing it were made up of cysts containing fluids of different densities, colors, and other physical properties. The pedicle appeared to arise from the rectum, at all events, the cyst wall was separated from everything else, except the front of that intestine, and the only ligature used was there applied. The whole vascular supply was derived from meso-rectal vessels. Of course, the clamp could not be used. As always, in sewing up the incision in the abdominal walls, I carefully included the peritoneum in the sutures, as in this way adhesions of intestine and omentum, with the consequent discomfort and constipation suffered by the patient, are never observed, and, moreover, in case a second ovariotomy should have to be performed, the operation could be performed with much more ease and safety.

This patient recovered from the operation, though somewhat slowly, owing to the delay and difficulty in removing the ligature, which was left hanging out of the external wound, and not cut short and left inside the abdomen, as is now generally practised. She remained in perfect health for seven years, but in the summer of 1882 came to my office complaining of considerable discomfort in the pelvis, where I detected, by the touch, the presence of a swelling, caused by a thick, viscid fluid; in other words, there was plainly a second tumor formed there. This continued to enlarge, and in the month of January, the suffering it occasioned was so immediately threatening to the patient's life, that it was necessary to act. Great efforts were made to push the tumor out of the pelvis, but this was not to be accomplished. It remained to operate as before, and remove the mass by laparotomy, or to give relief by emptying the cyst by tapping through the vagina. The latter procedure was preferred, and about three pints of a very thick, dark-colored fluid were drawn off by a Thompson trocar. There was no difficulty about the operation, nor was it attended by any particular pain, nor was there any hemorrhage. The

next day the patient felt herself completely relieved, but after that her pulse became quickened, and a general febrile condition, unpreceded by chill, succeeded. There was evident tenderness on pressure over the lower part of the abdomen, but no severe pain independent of this pressure. The stomach became so irritable as to reject everything swallowed. Death took place on the eighth day, under the marked symptoms of depression which accompany pyæmia. It was a death, most plainly, from cyst inflammation.

Notwithstanding the great number of cases of operation for ovarian disease reported nowadays in journals, more or less medical, this case is really one deserving of record, and, one of true and special interest to the pathologist and to the surgeon.

In removing the large mass in the first operation, in this case, it was noticed that no pedicle was found. It was separable by the fingers everywhere except from the front of the rectum, where it was necessary to apply a ligature and divide the attachment by scissors. The ovaries, as we all know, are situated in the posterior fold of the broad ligaments, on the sides of the highest part of the uterus, behind the Fallopian tubes and the round ligaments, which separate them from the bladder, and in front of the rectum, from which they are commonly separated by the lowest circumvolutions of the ileum. By a rounded cord, the ligament of the ovary, they are attached internally to the womb, and externally by two folds of the peritoneum to the sides of the pelvis.

As the ovary, in its normal condition, is not pediculated, at first, of course, a diseased ovary has no true pedicle. As it becomes larger, this pedicle is formed from changes in its normal connections with the adjacent womb; it consists of the Fallopian tube often much elongated, the broad ligament often considerably thickened, the utero-ovarian ligament occasionally hypertrophied to a large fibroid stem, the round ligament, and enlarged bloodvessels. If the tumor rises out of the pelvis the pedicle will be longer, and if bound down in the pelvis from early adhesions it will be shorter.

In some cases, however, and they are by no means rare ones, when cystic tumors are removed from the abdominal cavity, no such pedicle as the one just described is met with. In the case, whose history I have been relating, it was said that there was no distinct pedicle, and that the whole vascular supply came from the vessels of the meso-rectum. It may naturally be supposed that this was owing to the way in which the diseased mass may have been separated from its surroundings, and I therefore call attention to the fact that the same thing has occurred in the practice of an operator such as Spencer Wells. In his *Diseases of the Ovaries*, in relating Case CX., he says that he found no pedicle, and that the tumor derived its vascular supply from the omental and mesenteric vessels.

It seems to me most reasonable to look upon some of the abdominal tumors having these connections, not as enlarged and diseased ovaries, but as changed ovules, which have failed to enter the Fallopian tubes, have slipped in the interstices of the neighboring organs, become attached, received blood, and grown. In women when the Fallopian tube has become adherent, in place of floating loosely, the ovule is not grasped as it leaves the ovary, and then it is not rare to see ten, fifteen, twenty, or even more small cysts, some as large as a pea, on the parts immediately in contact with the ovary. (See Sappey, vol. iii., p. 644.)

If one of these misplaced ovules was attached to a spot, where plenty of blood was supplied, a large cyst could be formed, having no distinct pedicle, as in the case before us. As is seen in cases of extra-uterine fœtation, a well-made child can be formed in this way from a fecundated ovule, and we may suppose that from an unfecundated one a monstrous polycystic growth should form.

Although out of the way, I wish to mention here that the only two cases in which I have been consulted on account of a return of abdominal cystic tumors, were where there was no pedicle, and where the chief vascular supply came from the vessels in front of the rectum. One case is the one now under consideration, and the other is the one published in the *American Journal of the Medical Sciences* for January, 1883, on account of the bladder having been opened during the operation.

My reason for reporting this case, however, is not to advance any particular views in regard to the pathology of certain polycystic tumors of the abdominal cavity, but in order to speak of the mistake made in the treatment. In the words of one who has done as much as any other to advance our knowledge of the treatment of abdominal tumors, "Mistakes teach most valuable lessons, and, when discovered, are not likely to be repeated. Hence, in medicine, they should be recorded for the benefit of science and of humanity." (*General and Differential Diagnosis of Ovarian Tumors*, by Washington L. Atlee, in Preface.) When this case presented itself, it was necessary to act; a speedy and most painful death was inevitable unless relief were afforded. It remained to choose between the removal of the cyst and the emptying of its contents by tapping through the vagina, the only way practicable of introducing a trocar. On account of the operation previously performed, and the impossibility of moving the mass in the pelvis, its removal was not attempted. A previous operation is not necessarily an objection; Dr. Washington L. Atlee records two cases where a second operation was performed, and in both successfully. Spencer Wells, in his table, gives thirteen cases in which he removed an abdominal tumor from a patient who had previously undergone the operation, and eleven of them were successful. Here, however, the immovability of the tumor was such as to make positively sure that the attachments were so great as to render its removal impossible,

Of tapping through the vagina I had no personal experience whatever, and what is recorded by others, although not, as a general rule, favorable to the plan, did not deter me from it. Scanzoni goes so far as to say that if puncture by the vagina was always possible, abdominal puncture would soon completely disappear from surgical practice. The sac, opened in its lowest part, can empty itself more completely. (Scanzoni, *Traité practique des Maladies des Organes sexuels de la Femme*, Paris 1858). Peaslee says that there are three considerations to deter us from it in all ordinary circumstances: 1st. The vessels are longer and more numerous at the lowest part of the tumor; 2d. If polycystic, the largest cysts are not at its lowest part; and 3d. There is greater risk of wounding other organs. (Peaslee, *Ovarian Tumors, their Pathology, Diagnosis, and Treatment, especially by Ovariotomy*, 1872).

Emmet writes that he has punctured several cysts with a trocar from the vagina, and in every instance more or less cellulitis has resulted. This might, however, destroy the cysts, but he is not able to determine that, for all the cases passed from under his observation. (Emmet, *Principles and Practice of Gynæcology*, 1880).

Thomas says that by this method two of the dangers of tapping, secondary escape of fluid into the peritoneum, and consequent peritonitis, are unquestionably avoided, but others are as surely increased, namely, those of injury to portions of the intestine and entrance of air into the sac, with consequent decomposition of the contents, septicæmia, and inflammation of the sac walls. His experience with the method is not large, but it leads him to agree with Spencer Wells. Thomas, *Diseases of Women*, 1872).

Spencer Wells says that tapping through the vagina is more liable to be followed by inflammation of the cyst than tapping through the abdominal wall, because it is not easy to prevent the entrance of air. The operation of tapping through the vagina is selected, not so much with the intention of simply emptying the cyst, as for the chance that should the fluid escape by the opening, as fast as it is secreted, the cyst may gradually contract, and the puncture close. This favorable result, however, is seldom secured. As a rule, air enters the cyst, the opening fills up, the fluid remaining in the cyst, or that newly secreted putrifies. Suppurative inflammation of the lining membrane of the cyst comes on, and is accompanied by a low form of septic fever or pyæmia, which can only be relieved by making and maintaining a free outlet for the discharge. The frequency of these consequences should make tapping by the vagina an exceptionable practice, but it may be adopted in cases where an ovarian cyst is bound down in the pelvis by adhesions, and it is necessary to relieve the distress caused by pressure on the badder and rectum.

The canula or an elastic catheter may be left in the cyst, though it is safer practice either to introduce a wire seton or a drainage tube, so as to

prevent the opening from closing, and make sure of the free and immediate escape of any fluid that may be secreted. Even with every care, however, Mr. Wells concludes, from his experience, that patients are so apt to suffer from some of the ill effects of long-continued suppurative processes, that it is better, even at considerable risk, to remove a cyst, if at all possible, than to trust to any mode of drainage. (Spencer Wells, *On Ovarian and Uterine Tumors, their Diagnosis and Tréatment* 1882.)

Dr. Charles West, whose opinions have for me, at least, extraordinary importance, greater indeed on such a point than those of any other man, says that there is no doubt but that inflammation attacking parts within the pelvic cavity is less apt to extend to the peritoneum than when it attacks an abdominal organ; of which rule pelvic cellulitis and inflammation of parts within the folds of the broad ligaments are apt illustrations. It is equally incontestible that pelvic peritonitis is less apt to become generalized than is similar mischief originating in the abdomen. Cyst inflammation is so dangerous, however, that it is doubtful if vaginal tapping may be employed, even when the cyst is simple. Its dangers are incalculable. The dangers of ovariotomy are far less. Except when a cyst is impacted in the pelvic cavity, he does not recommend tapping per vaginam. (West, *Lectures on Diseases of Women*, 1879.)

Our best authorities, therefore, teach us that the tapping of polycystic tumors at least must be avoided; that the removal of the cyst is to be practiced in preference; that when impacted in the pelvis, so that it interferes with the performance of functions absolutely necessary to life, tapping, to which we must have recourse, is particularly dangerous, owing to the frequency of cystic inflammation, and consequent death from septicemia. In my case I thought to avoid this by taking precautions to hinder the entrannce of air into the cyst, but it took place notwithstanding, and the death of the patient was occasioned by it in eight days.

If, unhappily, I should ever again be called upon to try to relieve a similar case, I should act differently, and, not relying upon any means to prevent the setting up of cystic inflammation, do more to establish a free outlet for the noxious products by which the system is poisoned, and do everything in my power to prevent their formation by topical applications to the secreting surfaces of the cyst.

Dr. Noeggerath (*Ovariocentesis Vaginalis*, *American Journal of Obstetrics*, May, 1869), by pursuing this course, had such good results as to declare himself confident that, where a simple or compound cyst could be attacked through the posterior vaginal cul-de-sac, this operation would take the place of laperotomy. The plan he prefers is to make first a transverse incision, about an inch long, behind the cervix uteri and through the roof of the vagina up to the cyst. This, coming into view, is then evacuated by a free incision, and, finally, the edges of the two incisions are stitched together by five or six silver sutures. The cyst thus left free and perma-

nently open is daily washed out with antiseptic injections until it finally contracts, and ceases to afford any secretion. Although, at the present time, it is not likely that in ordinary cases any one would choose to perform this operation to that of the removal of the cyst, yet all experience shows that when the cyst is so firmly fixed in the pelvis as not to be removable, it diminishes in a marked degree the great danger necessarily incurred by tapping through the vagina—that of poisoning of the system by the absorption of the putrid products of cystic inflammation.

I feel certain myself that I made a sad mistake in not operating in this way, and report this case, as a warning to others—*Bene facit qui ex erroribus aliorum, sibi exemplum sumat.*

DISCUSSION.

Dr. William Goodell said that he did not think the attachment of the tumor to the rectum was so unique as the return of the tumor. He had on several occasions removed tumors without being able to find the true pedicle, on account of the many adhesions. He could not agree with Dr. Atlee with regard to the origin of the cyst—he did not think it could have come from a wandering ovum, since, in that case, it would have been monocystic.

He regarded tapping per vaginam hazardous, for the reasons given by the late Dr. Peaslee, first, on account of the danger arising from the entrance of air into the cyst. He did not understand why the air could enter the cyst so readily after tapping per vaginam. When he performed tapping by this method he employed the aspirator. Returning to the question of the attachment apparently of the pedicle to the rectum, in the case reported, he said that it was quite common not to find a pedicle in some forms of intra-ligamentous cyst, because they had to be enucleated, and referred to the statements of Lawson Tait with regard to this difficulty of determining the origin of the tumor. He desired to call attention to the pathological characters of the recurrent growths, and stated that according to his observation they were always malignant, and that they recur in the stump of the pedicle, or, as he had seen, at the site of the adhesions. He alluded to a case which occurred in his own practice, and to one related to him by Dr. Bantock, of London, which confirmed the statements made.

He asked Dr. Atlee whether he could explain why the air entered so readily into cysts after tapping per vaginam.

Dr. Atlee in reply said that he had seen no reason given, but thought it was owing to the difficulty in closing the wound made in the tapping.

Dr. R. P. Harris remarked that perhaps he could throw some light upon the cause of this admission of air, from what he had observed in a case of removal of hemorrhoids. Some years ago, soon after the introduction of the écraseur of Chassaignac, he called in the late Dr. Joseph Pancoast, who had obtained the instrument, to make use of it in remov-

ing a mass of hemorrhoids from the rectum of a very anemic man, rendered such by repeated hemorrhages after defecation. After the operation, to prevent, as he stated, the suction power of the diaphragm upon the rectum, endangering secondary hemorrhage, Dr. Pancoast introduced into anus a small box-wood tube. The effect of this was soon demonstrated: a large drop of serous fluid descended the tube and stopped at its exist; when the diapraghm arose in expiration, the drop was drawn up the tube, and when it descended in inspiration, it came down again; thus showing the pumping effect of the diaphragm upon the pelvic contents. Let this open tube become an opened cyst with flaccid walls, and we have air pumped into the cyst, as it was in the rectum of our patient.

Dr. J. Ewing Mears asked Dr. Atlee whether a post-mortem examination had been made. He thought the observations of Dr. Goodell with regard to the difficulty of finding the true pedicle in tumors with many adhesions, and to the pathological characters of the recurring tumor in these cases to be correct, as such had been his experience in instances of which he had had personal knowledge. With regard to the entrance of air into the cyst, when tapping is performed per vaginam, he thought the explanations of Drs. Atlee and Harris were correct. A cyst firmly impacted in the pelvic cavity is separated from the vaginal tube by a comparatively thin septum, differing greatly in its anatomical characters from the abdominal wall. The opening made by the trocar in this septum and in the cyst wall attached to it by adhesions, does not close perfectly, and the air drawn up into the vaginal tube passes readily into the collapsed cyst.

Dr. Atlee, in reply to Dr. Mears, stated that no post-mortem examination had been made.

OBSTETRICAL SOCIETY OF LONDON.

Wednesday, December 6th, 1882.

J. Matthews Duncan, M. D., President, in the chair.

Deciduous Membrane.—*Dr. Cleveland* exhibited a fleshy finger-like sac, passed forty-eight hours after labor, by a patient who after a former labor had passed a similar substance, which he had then exhibited to the Society. After careful search, he had found no trace of a double uterus.

The President could think of no other origin for such an unbroken decidua than that it came from an uterus bicornis.

Dr. Wynn Williams described a case of double uterus at present under his own care.

MICROSCOPIC SECTIONS OF CARCINOMA UTERI.—*Dr. Edis* showed microscopic sections illustrating his case of malignant disease of the cervix complicating pregnancy. The amount of stroma was small, compared with that of the cells, the appearance thus resembling that of medullary cancer.

PERIMETRIC ABSCESS.—*Mr. Griffith* showed a specimen of perimetric abscess, situated behind the uterus and left broad ligament, displacing and obstructing the rectum, and opening at three places into the cervix uteri, vagina, and rectum.

THE DIRECTIONS OF UTERINE CONTRACTION.—*Dr. Godson* showed an uterus removed by Porro's operation, which demonstrated well the wrinkles on its peritoneal surface caused by the contraction of its muscular fibres underneath.

Dr. Routh had heard the uterine *souffle* by the vagina or over the sacrum in cases in which he had failed to hear it by auscultating the abdomen.

RETAINED PLACENTA.—*Dr. Wynn Williams* exhibited a placenta retained for three months after abortion, and removed by him.

FIBROIDS REMOVED BY ABDOMINAL SECTION.—*Dr. Bantock* exhibited five specimens of uterine fibroids, weighing respectively 3 lbs., 8 lbs., 13½ lbs., 3 lbs., and 2 lbs., removed by abdominal section. One patient died, four recovered. In each case, the pedicle was secured by Kœberlé's *serre-nœud*, upon the value of which Dr. Bantock remarked. He thought that, whatever might be the future of oöphorectomy for the cure of fibroids, it could not compete with hysterectomy in cases such as those exhibited, in each of which there were substantial objections to the former operation.

Dr. Robert Barnes thought fibroids such as Dr. Bantock had shown better dealt with by hysterectomy. At present, he inclined to think Battey's operation best suited for hard fibroids in the wall of the uterus and projecting inwards. Malignant and myxomatous tumors it was better to extirpate. He could speak from clear observations of the remarkable effect of Battey's operation upon fibroids. Within a year after this operation, he had found a tumor the size of the fist practically gone.

Mr. Knowsley Thornton did not think hysterectomy should be performed for fibroids until oöphorectomy had been tried and failed. He had done the latter operation ten times: all the patients had recovered; all had been benefited; and in all the uterus had diminished in size, in some to a surprising degree. Not merely the ovaries, but the tubes, and the large vessels in the broad ligament, ought to be removed.

Dr. Godson corroborated Mr. Thornton's statement as to one of the cases operated on by him.

Dr. Champneys asked Mr. Thornton in what cases he thought the operation should be done.

Mr. Thornton thought only in cases in which life was threatened.

NEW LAMP.—*Dr. Aveling* exhibited a modification of Swan's incandescent carbon lamp, so made that it could be introduced into cavities of the body for operative or endoscopic purposes.

RUPTURED PERINEUM: NEW METHOD OF OPERATING.—A paper upon this subject, by Dr. Wynn Williams, was read. In this operation, the sides of the rent were first denuded in the usual way. Then a flap of elastic tissue, about two-thirds of an inch in width, about two lines in thickness, and long enough when on the stretch to reach as high as the denuded surface on the labia, was dissected up from the floor of the vagina. Sutures were then passed through the denuded surfaces, in such a manner as to keep the edges as well as the flat surfaces of this flap in contact with the raw surface. This being done, the sutures were secured in the usual way. When the rupture involved the sphincter ani, the flap was made, and the sutures passed through in the same way as in the simpler cases; but the rent in the wall of the rectum was sewn up with sutures made to terminate within the bowel, and the deep sutures secured before those bringing the flap into position were tied.

Dr. Aveling asked what Dr. Wynn William's practice was with regard to the action of the bowels after operation.

Dr. Bantock objected to the practice of tying the knees together, and also to the use of vaginal injections after operation. He performed Dr. Wynn Williams's operation once, but was not much impressed by it.

Dr. Cleveland thought that rupture of the perinæum could often be prevented by restraining the too rapid emergence of the child's head, which could be done by judicious counter-pressure.

Dr. Savage thought the difference was over-looked between mere tegumentary lesions, and rupture extending through the perineal body. In Dr. Williams's operation, a narrow tongue of tegument was reserved in the course of denudation, and plastered over the crevice left after bringing the raw surfaces together. No additional strength resulted from this, because the tongue was merely tegumentary. Early operations were tegumentary, and failed altogether. The perineal body was the centre of attachment of the perineal muscles, and the mainstay of the floor of the pelvis.

Dr. Routh thought that rupture of the perinæum could not always be prevented, and sometimes a slight laceration was not so great an evil as prolongation af the labor. He had in early practice, succeeded completely with ordinary sewing needles and thread. He concurred with Dr. Savage's remarks as to the perineal body; but had seen that the perinæum made by Dr. Williams's operation was remarkably strong and effective.

Mr. Knowsley Thornton thought this mode of operating gave remarkably good results; but it was not new, having been described by Mr. Teal of Leeds, and practised by many American surgeons.

Dr. Murray had seen the operation now described, and thought it gave a firm perinæum. It was not always prudent to retard the progress of the head. Laceration of the perinæum might often be prevented by making one or two lateral cuts.

Dr. Campbell Pope said that primary union might often be obtained by applying a broad strip of plaster to hold the nates together.

Dr. Edis said that rupture might often be prevented by straightening the legs while the head was emerging, and also by making a nick on each side of the perinæum. Union might be obtained by operation twelve or twenty-four hours afterwards. It was unnecessary, and rather jeopardised healing, to keep the bowels constipated after operation.

Dr. Culver James had in one case operated immediately after labor with a rather large common household needle, and obtained union.

The President had seen the results of many methods of operating, and could not say that one was better than another. He had stitched up a perinæum two weeks after delivery without denudation or cutting of any kind, and it healed sufficiently.

Dr. Wynn Williams did not confine the bowels after operation. The perinæum made without the flap he had described was apt to be too thin. He was not aware that his operation had been described before; it certainly was not alluded to in any work on gynæcology.

Pregnancy complicated with Cancer of the Cervix: Cæsarean Section Recovery.—This paper, by Dr. Edis, was read. The patient came to the Middlesex Hospital in November 1881. She had begun to suffer from pain, hemorrhage, and discharge eleven months previously. She presented the signs of six months' pregnancy, and there was epithelioma, involving nearly the whole circumference of the cervix, and the greater part of the posterior vaginal wall. Palliative treatment was adopted until February 1882. Labor-pains then came on, and the os dilated to the size of a five-shilling-piece. It being judged impossible for delivery by the natural passage to take place, Cæsarean section was performed by Mr. Morris. The child was born in a state of suspended animation, but recovered. The mother recovered; and, when she was seen in September, the disease had made but little progress.

Two Cases of Labor complicated by Cancer of the Cervix Uteri,—These cases were related in a paper by Dr. Herman. In the first case, the diseased tissue was freely cut away with scissors and the actual cautery, and deliverey effected with forceps. A vesico-vaginal fistula subsequently was formed; then phlebitis set in, and the patient died on the 18th. The fistula occurred at a spot which the cancer had invaded. In the second case, masses of diseased tissue were removed with the *écraseur*, the fingers, and scissors, with only trifling hemorrhage, and delivery was effected with forceps. The mother recovered well. The author thought that, in the management of labor obstructed by

cancer, the first alternative to be considered should be whether it was not possible to break down, and tear or cut away (the former preferably), the obstructing diseased part.

Dr. Bate had had a case of labor, with commencing cancer, in which delivery was effected by natural efforts but the patient died from septicemia.

Dr. Champneys said that, in these cases, it was, perhaps, most important that there should be healthy tissue at the sides of the cervix, for it was there that laceration most often occurred.

Dr. Galabin inquired as to the method of suture of the uterus adopted in Dr. Edis's case. He had in four cases of cancer delivered by the natural passage, in only one there being great difficulty in doing so; but two of the mothers died: in one of the latter, the disease was almost entirely removed with the galvanic cautery.

Mr. Jennings thought that rupture of the bladder, during parturition, was not so rare as might be supposed.

Dr. Fancourt Barnes thought that, in these cases, Cæsarean section offered a chance of probable recovery to the mother, and certain safety to the child. An important point was that, in this operation, healthy tissues were cut through, while in natural delivery diseased tissues were torn, thus favoring blood-poisoning.

Dr. Edis said that, in his case, interupted sutures of silkworm-gut were used.—*British Medical Journal.*

EDINBURGH OBSTETRICAL SOCIETY.

Session of February 14, 1883.

The President, PROFESSOR SIMPSON, in the chair.

UTERUS REMOVED TWENTY-FOUR HOURS AFTER DEATH.—Exhibited by *Dr. H. Croom.* The case before death was diagnosed as one of hydatids. The patient died of phthisis and hemorrhage from the uterus. On dividing the uterus a black mass was found, which Dr. Croom believed to be hydatids, but which he had not yet been able to examine; but as the uterus will be handed over to the Pathological Committee, the results of their investigations will be given to the Society at some future time.

Dr. Croom also, for Dr. Sinclair, exhibited a case of exomphalos.

A NEW FORM OF BIVALVE SPECULUM.—After expressing disapproval of all other forms of specula, *Dr. Reid* stated that he had made several attempts to find something more suitable for his purpose. After several failures he had at last succeeded, and claimed the following advantages for the one exhibited:—Efficiency; a good view of all parts permitted;

does not interfere with cervix; easily used; suits all vaginæ; dilates all parts of the vagina at will of operator; very probably saves pain to the patient and time to the operator; and may be used in all positions of patient.

Dr. Croom thought that the instrument might be very useful, but he now seldom used a speculum, as he thought that by the bi-manual method of examination a speculum was now seldom used, except for operations, and then he found Sim's speculum all that was needed.

Dr. Peter Young thought that, as the speculum was in peices, in practice one of the parts might be lost or mislaid.

Dr. Bruce wanted to know if the walls of the vagina fell in between the valves.

Prof. Simpson did not quite agree with Dr. Croom as to being able to discard the use of the speculum, and he thought that the speculum exhibited for a bi-valve was likely to prove a most useful instrument. At the same time he suggested that the ends of the blades should be broader than those of the one exhibited.

On Obstinate Vomiting during Pregnancy.—*Dr. Brock* (Glasgow) after mentioning the views as to the cause of this complication given by former writers, gave a description of some cases he had attended, and stated that, as other observers had neglected an examination of the urine for albumen, he had carefully examined the urine in one case, a full account of which he gave. Every attempt to prevent vomiting in this met with little success, the tincture of iodine, in 5-7 drop doses, and morphia, seeming alone to prevent the vomiting for a time, and he then decided to bring on premature labor, which he did, with immediate relief to the patient, the albuminous condition of the urine disappearing in a day or two. After some months the patient again became pregnant, and with symptoms like those before described, and again premature delivery saved the patient. Dr. Brock, after challenging the opinions of other writers, suggested that the vomiting in pregnancy is not due to any condition of the uterus, but is probably due to some peculiarity on the part of the patient, probably of a neurotic origin, and this he maintained was, as a rule, the cause of persistent vomiting in pregnancy, and not in the albuminuria, to which he had before drawn attention, and which he did not consider as primary, but as due to the neurotic affection, which was probably also the cause of the sickness. This view was supported by the following considerations: 1. Albuminuria in the non-pregnant state does not necessarily cause vomiting. 2. Albumen is frequently present in the urine in the pregnant state, and vomiting is not a more marked symptom in patients with albumen present than in those where the albumen is absent. 3. The ordinary sickness of pregnancy does not take place without traces of albuminuria, and severe and fatal cases occur where the urine is free from albumen, if it may be inferred from reports of such

cases being silent on the point that no albumen existed. It could scarcely be secondary, for the following reasons:—1. The albumen was totally absent on several occasions during the course of the illness, and entirely disappeared immediately on the cessation of vomiting—an occurrence which was unlikely to happen if the albuminura in the first instance was caused by poisoning or impoverishment of the blood. 2. As stated before, severe cases, fatal from exhaustion, are reported where no allusion is made to the presence of albumen in the urine. 3. Albuminura is frequently present in the pregnant state when there is no reason to believe there is the slightest poisoning or impoverishment of blood. 4. Obstinate and long-continued vomiting, at least in the non-pregnant state, does not necessarily produce albuminuria.

Dr. Peter Young did not consider the explanation of the cause, as given by Dr. Brock, at all satisfactory, and maintained that all Dr. Brock suggested was that in some nervous females vomiting did occur—in fact, was a neurosis. He suggested that the ganglia at the cervix became excited during pregnancy, and may produce the vomiting by reflex action. He also recommended the use of the tincture of aconite in small doses, as proposed by Hodges.

Prof. Simpson congratulated Dr. Brock on the value of his paper. He did not clearly see the connection between persistent vomiting in pregnancy and albuminuria.

Dr. Brock replied to the remarks of Dr. Young, and reiterated his opinion that the affection is purely of neurotic origin.

The Prophylaxis of Ophthalmia Neonatorum.—*Prof Simpson* then read his paper on a disease more discussed on the Continent than in England. The disease has been suggested to be due to discharges from the vagina of the mother. Attempts to prevent it by washing out the vagina of the mother did not succeed; but the bathing of the eyes of the infant with a dilute solution of carbolic acid proved more successful. In Leipsic the use of a two per cent. solution of nitrate of silver to the eyes of the infants in the maternal hospitals was attended with a marked success. Prof. Simpson recommended that the eyes should be washed with water as soon as the head is delivered and the nitrate of silver dropped in soon after.

Dr. Bruce stated that the affection of the eyes is rare in private practice.

Dr. Croom used to syringe the vagina of all women in the Maternity, but without affecting the occurrence of the disease in the children. The cases in the Maternity Hospital are few and far between.

Dr. Robertson suggested that it might result bad in face cases from the finger of the attendant entering the eye.

Dr. Craig expressed considerable anxiety as to the record of any case of face presentation with mechanical injury to the eye.

Dr. Milne Murray and Dr. Wilson made some remarks on the subject, the former recommending in ophthalmia neonatorum due to gonorrhœa a solution of 75 grs. of nitrate of silver to the ounce.—*The Medical Press.*

Foreign Gleanings.

TRANSLATIONS FROM THE FRENCH AND GERMAN.

[Prepared for the Obstetric Gazette.]

Puncture of Ovarian Cysts.—A few years ago every ovarian cyst presenting a certain volume was punctured without hesitation. This was merely a palliatative measure, although sometimes the length of time elapsing before its again filling, made it equivalent to a cure, and in rare instances a cure was affected. Puncture followed by injections of iodine has never been generalized in practice. Since ovariotomy has taken such rank, puncture has been viewed in a different light. Some consider it useless and dangerous, néarly criminal, because endangering ovariotomy; others think it ought to precede that operation, while others taking a medium position think it useless in some cases and indispensable in others that are to be operated upon. With multilocular moderately developed cysts, ovaritomy on the start seems to us best. When the diagnosis is doubtful, one can have recourse to it. When the abdomen is distended, respiration difficult, legs swelled, it often puts the patient in better condition to support ovariotomy. It gives a chance for cure, for unilocular cysts large or small. Why has puncture been rejected? First there exists a sort of moral objection. The patient relieved, is deceived as to the definite value of this procedure, recoils from the greater operation, until weakened and miserable it is made under the least favorable circumstances. This consideration is of prime importance when we consider that the general tendency is to procrastinate. Puncture is not only not innocent, but may be deadly when it wounds the blood vessels or allows the cystic contents to get into the peritoneum. This is done when sufficient caution is not used, or when the trocar is too large. In aspirating a trocar of small calibre is sufficient. Sometimes the trocar is not clean; I have seen mischief done by using instruments that were not thoroughly cleaned and disinfected. I wash the trocar in a twenty per cent. carbolized solution, pass it through the flame of an alcohol lamp and run boiling water through the canula. I bathe the point to be punctured in strong carbolized water, placing over it a piece of linen wet with the same. Instead of oiling the trocar I moisten it in a carbolic solution, or if I

think necessary to oil it use carbolized oil. I always perform this operation with simple but efficacious antiseptic precautions, and have never met with any accidents. Regarding the formation of adherences caused by puncture, it is a rare result, and when it does happen, they are not solid and situated anteriorly are of slight importance. Puncture for diagnostic purposes, for rendering the patient more comfortable and improving her general condition, is practiced by Spencer Wells. In the last few years we have had cysts of the broad ligament, originating outside of the ovary in the organ of Rosenmuller, unilocular containing a crystal clear non-albuminous and non-coagulable fluid, cured by one or more punctures. I have performed ovaritomy twice upon these parovarian cysts. There was a slow return of the symptoms. In both cases the ovaries were removed. In the first case they were covered with varices, in the second they contained tiny cysts. While it is necessary to operate as soon as possible on ovarian cysts, this does not prevent puncture when there is an enormous distension; but it should not be too often repeated, nor done without antiseptic precautions. M. STANTON.

THE WATER-BED AS A LYING-IN-BED.—You all remember the young primipara who was sent in for artificial premature delivery. She was in the eighth lunar month, and was suffering from morbus brightii. The nutrition of the parts was disturbed by the enormous swelling, and the lesser labia had become gangrenous. The vicinity of such a patient endangers the others. So we put her in a room alone, giving her her own nurse and physician, who were not even to enter the lying in wards. We did not consider it advisable to bring about delivery in the mother's condition. In any case, the prognosis for both mother and child was bad. The child had been poorly nourished, must be imperfectly developed and too weak to live, while the mother's chances of recovery in the present state of affairs would be lessened by artificially produced labor. The lymphatics would become engorged with this rotten mass, lymphangitis resulting, then the areolar tissue would be involved, and finally our patient would succumb to septic-peritonitis. Her treatment consisted in frequent irrigation of the vagina with a three per cent. carbolic solution, and thymol dressing to the vulva with appropriate diet. We were expectant three days, on the fourth she gave birth naturally to a 2100 grm. living child. The gangrene spreading we had her placed in a water-bed, in which she has been now five days, without fever and with a good appetite. To put a lying-in woman in a warm bath seemed until recently a strange thing, but theoretically there is nothing against it. The spread of the gangrene is stopped, the putridity is swept away, and she feels perfectly comfortable.—*Prof. C. Braun's Clinic.* M. STANTON.

Abstracts and Selections.

I.—OBSTETRIC.

Retention of a Detruncated Head and the Placenta in Utero for Forty days.—This astonishing case is reported in a recent number of the *Archiv für Gynäkologie* by Dr. Alois Valenta. The patient was thirty-five years old, and this was her fourth child. Labor came on at term, the child presenting with the shoulder. A medical man was called, who proceeded first to detach the lowermost arm, and then to bring down the feet. He delivered the body, but could not get the head to follow, so he cut through the neck and left the head behind. Two other doctors were then called in, but all they did was to administer ergot and advise that the patient should be taken to a hospital. This her husband would not hear of, and so nothing was done. Eight days after the medical man had seen her, a midwife was called in; but she did nothing except syringe the vagina with warm water every two or three days. The patient all the time had no bad symptoms—no rigor, no particular pain, no bladder or rectum trouble, ate well, and slept well; the only thing was that she felt weak, and that the lochia stank insufferably. Thirt-eight days after the labor the patient rebelled against marital authority, and had herself taken to the hospital. When seen there, her pulse was 72, temperature 99.5°. There was no sign of uterine action, and the uterus seemed to have undergone complete involution, being spread like a thin cap over the retained head. Three days after admission, the vagina having been first repeatedly syringed with a three-per-cent solution of carbolic acid, the cervix was dilated with sponge and tupelo tents, and repeated doses of ergot were given. This brought away discharge and small fragments of bone, but the patient felt no pain, although intermittent hardening of the uterus was perceptible. After dilation, the bones of the fetal head were seized, as they could be got at, with strong polypus forceps and carefully removed. The chief difficulty was found with the parietal bones, which were in such close coaptation with the uterine wall that it was difficult to seize them, and when seized, it was necessary to double them up (a thing not easily done) in order to get them through the cervical canal. About forty bits of bone were taken away. Then the placenta, which looked quite fresh, was detached with the finger and removed piece-meal—a proceeding which occasioned some hemorrhage. The whole operation occupied about an hour and a half. When it was finished, the uterus

was washed out with hot water, and ergotine injected subcutaneously. The patient recovered without a bad symptom. Dr. Valenta has only been able to find in literature one case resembling this. This is recorded by Freund. In his case the detached head was retained for ten years, the uterus, as in Valenta's case, showing no inclination to expel it.—*The Louisville Medical News.*

Mr. Spencer Wells' Ovariotomy Statistics.—The following correspondence on this subject appeared in a recent issue of *The Medical News:*

To the Editor.—Dear Sir: I have just received from Mr. T. Spencer Wells the subjoined communication which I send to you at once in the hope that you will give it an early insertion in The Medical News as well as in the *American Journal of the Medical Sciences*. If your readers will refer to The News, of January 27th, they will find that the statistics of Mr. Wells' cases were furnished me by Mr. Thornton, and not compiled by me. They were originally intended for the new edition of my *Surgery*, but having reached me too late for insertion in that work, I obtained permission from Mr. Thornton to publish them in The News, where they appeared without one syllable or letter of alteration. In reading Mr. Wells' opening sentence, it might be inferred that I was the author of the statistics. It would have been well if the celebrated ovariotomist had said that the *statement* to which he therein refers had been based upon Mr. Thornton's statistics, as that would have rendered the matter perfectly clear as far as it concerns me. Mr. Thornton's statistics dealt only in generalities, and not in any details respecting the gradually diminishing mortality of Mr. Wells' successive series of one hundred cases. In doing this the distinguished ovariotomist had, I am sure, no intention of misrepresenting his friend Mr. Wells, for whom he has always cherished the warmest regard and highest esteem. It may gratify Mr. Wells, as it certainly does me, to know that the new edition of my *Surgery* contains an accurate account of his statistics derived from his own recent work on ovariotomy. I have the honor to be your obedient servant,

S. D. Gross.

My dear Professor Gross,—You have published in the *Philadelphia Medical News* a statement comparing the results of my operations of ovariotomy in 1,088 cases with those of three other operators in 381, 328, and 226 cases respectively, making a total of 935 cases. The mortality of my cases is given correctly at 22·15 per cent., and that of the other operators as 10·76, 10·67, and 11.94 per cent. On this plain statement, as you have published it, any one would conclude that I am a less successful operator than my juniors. Indeed, the author of a very eulogistic review of my last book in the *American Journal of Medical Sciences* of January, 1883, misled by a false statement in the *American Journal of Obstetrics* (vol. xv., page 547), that I "had gone on for twenty years

operating on hundreds of cases with a mortality of 25 per cent.," takes the trouble to give what he believes to be a true explanation of the "high range of mortality in his [my] ovariotomies." He says that I had labored for an "ideal success," but "his [my] own practice fell short of this ideal." If it were true that after twenty years' operating I had gone on operating with a mortality of 25 per cent., while others did not exceed 10 or 12, some such explanations as those proffered by my able and kindly reviewer might serve as my excuse. But it is not true. When I had been operating for twenty years I had reduced my mortality to 11.62 per cent. The results of successive series of 100 cases had been made known—from 34 in the first, and 28 in the second, to 17 in the ninth, and 11 in the tenth series of 100 cases. My cases of 1879, 1880 and 1881 had been published, with results of 11·62, 9·57, and 10·7 per cent., and in the preface to my book, published in May, 1882, I afford proof that, "notwithstanding the fact of my being often called upon to treat patients rejected by other surgeons as unfavorable cases, the progressive diminution of the mortality still continues." I added, "It is still more gratifying to be able to add that this increasing success is not confined to myself nor to British surgeons, but is also established in Germany, France, and Italy." There really can be no excuse for this attempt to discredit me with a high mortality after twenty years' experience, as in my book [pages 214–15] I had shown very plainly how in successive periods of five years the mortality progressively diminished, and that in the

First five years	about	1 in	3 died.
Second and third five years	"	1 in	4 "
Fourth five years	"	1 in	5 "
Last two years	"	1 in	10 "

Or, putting it in another form, that in the

First five years	70	per cent. recovered.
Second five years	74	" "
Third five years	73	" "
Fourth five years	80	" "
Two last years	90	" "

I trust, my dear Professor, that you will accept my desire to stand well with my American brethern as a sufficient excuse for this long letter. And, with sincere respect, I am, etc.,

3 Upper Grosvenor Street, London, T. SPENCER WELLS.
February 27, 1883.

The Electrical Treatment of Extra-Uterine Pregnancy.—Dr. A. D. Rockwell recently read a paper before the Harlem Medical Association, on the treatment of extra-uterine pregnancy, in which he referred to the first case which he was called upon to treat, a few years before, when the

question was asked whether it was possible to destroy the life of the fœtus by the electric current. He replied that it could undoubtedly be done, but another question was, whether it could be accomplished without injury to the mother. This question was answered in the affirmative by the results that followed. The case was one of tubo-instertitial pregnancy at third month. an account of which, written by the attending physician, Dr. Charles McBurney, appeared in this journal (vol. xxii, No. 3.) Three other cases successfully treated by Dr. Rockwell have also been published, the diagnosis in every instance having been confirmed by Dr. Thomas, and, in most of them, by Dr. Emmet also. More lately he has treated three other cases which have never been published, and which, if possible, even more strongly confirm the incalculable value of the treatment in these dangerous but somewhat rare abnormities of pregnancy.

One of these last three cases was a most interesting and unusual character, from the fact that with a normal uterine pregnancy was associated what, in the opinion of Dr. Thomas, was a tubal and extra-uterine pregnancy. Internal examination and conjoined manipulation revaled a tumor of about the size of a pullet's egg, situated about two inches to the left of the median line, nearly on a level with the brim of the pelvis, which could be moved from Douglas's cul de-sac toward the margin of the ribs. The tumor gradually increased until it was larger than a billiard-ball. In the treatment, one pole was introduced to the mass through the vagina, and the current was rapidly interrupted.

The maximum of current strength employed was eighteen cells, or, to speak more accurately, as different apparatus vary much in electro-motive force, a power of 24 vols. The operation was repeated on October 25-28, and 30, 1882, causing the tumor not only to decrease perceptibly in size, but to change its seat by an inch or so as well. Since the last application it has gradually grown smaller, until now it can barely be detected. At the same time a six months' fœtus is now developing in the uterus.

In these conditions Dr. Rockwell decidedly prefers galvanism to other forms of electricity, both from the teachings of experience and because of the well-understood superiority of galvanism in physical, chemical, and physiological action. In any case of tubal pregnancy, and especially in those advanced conditions where the tube is greatly distended, and there is danger of spontaneous rupture, the possibility of hastening this catastrophe should never be lost sight of.

The tubes themselves are but slightly supplied with muscular fibre, and the danger would more especially arise from the powerful compression that is liable to be exerted by the abdominal muscles, and the effort should be so to diffuse the current proceeding from the external pole as to produce the least mechanical effect possible. The diagnosis of extra-uterine pregnancy is not always an easy matter, and in the various cases

related the question might arise as to its accuracy. The eminence of the gentlemen associated in the cases, Dr. Rockwell thought, should be a sufficiently strong argument for the correctness of the diagnosis, but conclusive evidence, he thought, lay also in the effects of the treatment itself. The results of electrolysis are well known, but in no other form of tumor, cystic or otherwise, is it possible for the galvanic current, used as described, to produce such prompt results.

Native Midwifery in Ragoon.—The following case which occured in my practice, illustrating the barbarous custom among the Burmese in accouchement, may be interesting, and may lead to stringent means being adopted to put a stop to it. On Saturday, November 25th, I was called to the accouchment of a woman across the river at Dallah; on arriving there, I found the woman very much exhausted, and in labor-pains. On inquiry, I was told that she was in strong pains for the past four days; and on making an examination of the abdomen, I found a tight band encirling the body above the umbilicus. It was with great difficulty that I could get that removed, and it was only by my threatening to leave that my order was obeyed. On examination by the vagina, I found the os dilated to the size of a shilling. I used manual dilatation and ergot, and ruptured the membranes, and rapidly brought the head down on the perinæum. As the woman wished to attend to the call of nature, I retired to the next room, and on returning found the woman again tightly bound up. As I could not get the people around to remove the bandage, I told them to give her a little rest, and retired to the next room, where I could hear everything that was going on. Hearing a good deal of noise and commotion, I went into the room, and witnessed but for an instant the process of stamping the child out. Several women were arranged along side of the woman. One of them jumped upon the body, and stamped vigorously upon the abdomen; the woman's legs were apart, and several were watching the effect, and made an exclamation in chorus each time the head protuded from the vagina, amidst the shrieks of agony of the poor victim. In the short time I witnessed this I saw that the perinæum was ruptured right up to the anus. I caught hold of the woman and swung her off, when the next woman jumped on. I removed her also, when a third took her place. They were so excited, that they were more like maniacs than sane people. When I found I could do nothing with them, I took up my midwifery-case, and walked out. In spite of such extraordinary treatment, the woman is still living, but far from well. Another case has just come to my notice of a primipara, in which the woman was in lingering pains four days, and then the stamping process was adopted, resulting in the birth of a still-born child, and the immediate expiring of the woman. This occurred in the same place. In concluding, I may remark, that the result of death in the second case was, most pro-

bably, rupture of the uterus; whereas, in the first case, death was averted through the child being far advanced into the second step.—JAMES C. ADY, in *Brit. Med. Journal.*

Illegitimacy in Scotland.—At the annual meeting of the Edinburgh Maternity Hospital, on the 1st inst., Lord Provost Harrison, who presided, took occasion to refer to the crying evil of illegitimacy, which mainly necessitated the existence of the institution of which he was president. He remarked that but for miserable ecclesiastical contentions the question would have been manfully faced long ere now. Scotland had as much need to wage warfare with it as with vice of drunkenness. The scandal and sin of Scotland in that respect ought to make Scotland stink in the nostrils of all nations of the world. The vast mass of the respectable people of the country were totally insensible to; because ignorant of it. But he knew too well the frightful amount of human misery which was annually caused in the land by the sin to which he referred. He did not so much blame the guilty parties as the conditions of society in which they were, and the low standard of public opinion which they had allowed to grow up in the society to which they belonged. There were many places in Ireland, even in the wildest districts, where the fall of a young woman from chastity was practically unkown for generations. It was a shameful thing they should have this sin so common in Bible-loving Scotland, when such an immunity from immorality existed in Catholic Ireland. The courting customs of Scotland must be attacked; and he would be a benefactor to his country who would head a crusade against customs which annually broke many hundreds of young and beautiful hearts, which ruined hundreds of young lives, and filled hundreds of households with grief. Meanwhile, in Scotland the rival religious bodies were too much occupied in fighting one another to attend to such a matter as this. It were well that these sensible reflections were taken seriously, and an authoritative effort made to stem that tide of national degeneracy which has long blanched the fair fame of Scotland.

Dilatation of the Neck of the Uterus.—M. Chassagny, of Lyons, in a communication made to the Paris Academy of Medicine, describes his method of thoroughly plugging the vagina; and producing rapid dilatation of the neck of the uterus. He places in the vagina a bladder, with which an India-rubber tube is connected; this, with the help of a siphon, conveys into it the water contained in a receptacle placed about two feet and a half higher than the pelvis of the patient. The bladder becomes distended by the water, and soon fills the vaginal cavity. This brings on abundant secretion, and induces energetic contractions, resulting in the physiological dilatation of the os uteri, which is quickly completed by the mechanical action of the bladder. The bladder is placed in the

vagina, and the occlusion of the vulva is obtained by means of an apparatus which M. Chassagny calls the *Elytroptérygoide* (wings in the vagina). It consists of a cylindrical speculum, which holds the bladder; this is forced out as the water enters, and the act of distension separates the valves of the speculum, which, resting on the sides of the pelvis, prevent the expulsion of the apparatus and of the bladder. M. Chassagny mentions, in his pamphlet, several instances of induced premature labor, in cases of contracted pelvis, obstinate vomiting, eclampsia, etc. M. Chassagny describes two cases of vicious insertion. In both cases, he induced labor before the natural period by having recourse to rapid dilatation. There was not the slightest hæmorrhage, and two living infants were born. In another case, where the mother was in the last stage of suffocative catarrh, M. Chassagny effected, in half an hour, the safe delivery of a living child. The mother rallied for a few moments only. In *post partum* hæmorrhage, the bladder, by completely filling the uterine cavity, closes the openings of the vessels, and, by artificially restoring the pregnant state, determines uterine contraction. The water in the bladder slowly flows away, until the uterus is thoroughly contracted.—*British Medical Journal.*

Case of Interstitial Tubo-Gestation.—Dr. Henry Habgood describes the case of a married woman, aged 35, who died with all the symptoms of internal hemorrhage, in the eleventh week of pregnancy. "At the necropsy, there were about five pints of clotted blood in the pelvic and abdominal cavities. On turning this out, the source of the hemorrhage proved to be a sac, formed by the uterine portion of the left Fallopian tube and the wall of the uterus, which had grown outwardly to about the size of a walnut, and then ruptured anteriorly. Chorion villi were distinctly visible in the sac. The opening of the tube into the sac had become obliterated. There was evidence of a previous partial rupture, in the shape of a small hematocele, on the posterior aspect of the sac. The fœtus had escaped into the abdominal cavity, and was unfortunately lost. The left ovary was closely attached to the left side of the uterus by old bands of lymph, and contained several cysts. The right ovary was normal, and contained a corpus luteum. The uterus was enlarged, and its lining membrane was red and thickened, forming a distinct decidua, that could be easily detached. The bladder was healthy, but contained no urine. The abdominal organs were healthy, but very anæmic.

"With regard to the cause of the arrest of the ovum in that particular spot, I may remark that nothing existed in the Fallopian tube or uterus, in the shape of polypus or fibroid, to cause obstruction, but that there were plenty of adhesions on the left side, matting the uterus, Fallopian tube and ovary together, altering their relative position, and, possibly, causing obstruction. Yet the presence of a corpus luteum in the right

ovary, coupled with the cystic condition of the left, would point to the theory of trasmigration of the ovum as being the most probable explanation of the phenomenon."—*British Medical Journal.*

Treatment of Hysteria.—The cause or causes of the many-headed hysteria was sought in vain in the morbid condition of the organs; first, as the name tells us, in the uterus, afterwards in the ovaries, principally the left. Even after the extirpation of these organs, hysteria still continued to exist. Friedreich, in a short article, published after his death by Prof. Schuze, draws our attention to the fact that the clitoris and the pudendal nerve are also sources from which by reflex action many nervous disturbances may take their origin,—not through masturbation only, which only occasionally is the primary cause, but by involuntary conditions of excitation and local sensations produced by it, which naturally secondarily lead also to masturbation. More conclusive than this theoretical *raisonement*, Friedreich proves the connection by cases; at the same time showing us a remedy to produce a cure of the disease. Intense cauterization of the clitori with argentum nitras has produced a momentary cure in eight aggravated cases of hysteria, which previously had undergone many different modes of treatment without success. For instance: Paraplegia of the lower extremities, existing for 1½ years; hysterical aphonia, existing two years; glossoplegia, of eight months duration, a seven months tonic contraction of the accessorius muscle, etc. Since Friedreich recommends this remedy, it would be advisable to use it in proper cases. It can do no harm, and is certainly preferable to those organ-destroying operations, such as castration and clitorodectomy, recommended for the cure of hysteria.—*Virchow's Arch.*—*N. O. Med. and Surg. Journal.*

The Vomiting of Pregnancy.—Mr. Brock discards the numerous theories which have been proposed to account for obstinate vomiting in pregnancy, and believes that it arises simply and purely from an idiosyncrasy in the individual. Vomiting, of course, may be aggravated by other conditions present, such as undigested matters in the alimentary, canal, etc.

He thus summarizes his principal reason for coming to this conclusion:

1. That obstinate vomiting occurs in multipara, where the uterine tissues are lax, and where the os is soft, easily dilatable, and even patent enough to admit the tips of two fingers. This causes him to reject the theory held by Bretonneau and Barnes.

2. That obstinate vomiting is absent in the majority of cases where there is a rigid state of the os, and where one would almost expect it invariably to be present, if the cause were that assigned by Dr. Barnes.

3. That obstinate vomiting is often absent in flexions and distortions of the uterus, and often present where there are no flexions or distortions. This would not be likely if Dr. Hewitt's theory were true.

4. Obstinate vomiting is often absent in inflammation conditions of the uterus, and present when there are no inflammatory conditions. This ought not to be the case if Dr. Bennett's theory be correct.

5. Because he believes a parallel condition is to be seen in other affections clearly influenced by the individual's neurotic constitution; for instance, obstinate sea-sickness, the occasional vomiting that takes place in pseudocyesis, the proneness to convulsions in certain cases whenever ill; or, to take a specific case, the vomiting simulating the obstinate vomiting of pregnancy, in a non-pregnant woman, in whom the uterus is normal.

6. Because there is no definite line to be drawn between the ordinary cases in sickness in pregnancy and the more severe cases.—*Glasgow Medical Journal*, March, 1883.

New Method of Measuring the Diameters of the Pelvis.—Dr. I. E. Taylor, of N. Y., recommends the following method of measuring the diameters of the pelvis (*Amer. Jour. of Obstet.*, p. 190, Feb. 1883): Introduce the hand, and for measuring the transverse diameter turn the thumb towards the right or towards the left, and then estimate the difference between the diameter of the pelvis and the width of the hand, which can be done with the thumb. To measure the antero-posterior diameter turn the hand with the thumb towards the pubis, and make the estimate in a similar manner. Dr. T. believes that when the hand can be introduced, the operator will get a more correct view with regard to the antero-posterior, as well as the transverse diameter, than by any other method which can be employed. If, after introducing the hand into the pelvis, it cannot be rotated freely, it is safe to assume that the pelvis is generally contracted. He believes that the so-called justo-minor pelvis, or what he denominates the naturally faulty pelvis, occurs much more frequently than has been supposed.—*Maryland Medical Journal.*

Results of the Operation for the Total Extirpation of the Uterus.—Olshausen (*Archiv für Gynäkologie*, Bd. xx. Hft. 2) reports the results of his experience from the vaginal method of extirpating the uterus, and to the paper are appended expressions of the views of other operators. Twenty-three cases in all had been treated in this way by the author: three of these, however, were not completed. In one case on account of vesical growths, there occurred either recto-vaginal or vesico-vaginal fistulæ. Of the remaining twenty, fourteen survied the operation, six died. In nineteen there was carcinoma of the cervix, in three either cancer or sarcoma of the body of the uterus, in one there was only a small myoma of the posterior wall of the cervix. Of those who recovered from the operation, three were known to have a return of the disease, and two of them perished. He has abandoned the reversal of the uterus, and in the last eight or ten cases has used the elastic ligature exclusively. Irrigation with

carbolized solution during operation is frequently repeated. Afterwards a drain is established in Douglas's cul-de-sac, which is protected by iodoform gauze.

Martin, of Berlin, reported thirty-one cases of vaginal extirpation of the uterus. In five the operation was not successful in removing all the diseased structure. Of the remaining twenty-six, four died. He begins the operation by the opening of the posterior vaginal wall, and transfixes and ligatures the divided tissues, so that the subsequent operation is nearly bloodless. He still adopts the tilting over of the uterus, and also always uses drainage. As regards return of the disease, his operations have not been very successful; only a single patient remained free from disease eighteen months after the extirpation.

Kuglemann, of Hanover, had not as yet seen a successful case of carcinoma: he therefore considered the operation of total extirpation as applicable more to cases of adenoma with severe hemorrhages than to cancer. Without operation the latter class of patients suffer less than with it.

Sänger, of Leipsic, operated twice. Both survived the operation: in neither was there drainage. The operation was performed according to the method of Czerny-Schröder. In the first case, a return of the disease occurred, with the formation of a high intestino-vaginal fistula; the patient died ten and a half months after operation.

Olshausen had, in cases of tumor-like carcinoma of the intra-vaginal portion of the uterus, amputated the diseased part with sometimes permanent cure. He would restrict the operation of extirpation to cases of malignant new growth, but would not consider it applicable to a uterus merely because there is hemorrhage; in the latter class of cases castration is indicated.

Veit, of Berlin, considered in many cases of cancer of the cervix that supra-vaginal amputation would suffice, and had himself had several cases of permanent cure to report.

Renecker and Martin opposed the statement of Kuglemann, that a pronounced cancer of the uterus is beyond operation, and, in reply to Olshausen, Martin said that castration would not in all cases relieve that severe bleeding from the uterus, as one of his cases had demonstrated,—"*Verhandlung den Gynäkol. Sektion der Naturforscherverrammluug in Eisenach*," *Centralblatt für Chirurgie*, No. 3.—*Medical Times.*

Abdominal Section For Puerperal Peritonitis.—In a recent number of the *Wratsch*, Dr. Molodenkoff of Moscow describes the case of a woman, aged 28, who was admitted into hospital ten days after delivery, for diarrhœa, fever, and swelling of the hypogastrium. Ten days later, the abdomen was much distended, and on exploratory puncture purulent fluid was obtained. On the next day, an incision was made along the

linea alba, and a great quantity of pus emptied out of a circumscribed cavity formed between the abdominal wall and adherent coils of intestine. To facilitate thorough drainage, a second opening was made immediately above the symphysis; and after tubes were inserted into the wounds, the whole was covered in with antiseptic dressings. On the next day, symptoms of carbolic poisoning appeared. Much pus escaped, great prostration set in, and the patient rapidly lost strength, dying on the fourth day after operatinn. At the necropsy, ten smaller circumscribed collections of pus were found between coils of intestine, inaccessible to the drainage tubes, as they had been arranged, besides the large cavity that had been effectually drained. The mucous membrane and peritoneal covering of the uterus and the ovaries were acutely inflamed. Dr. Molodenkoff concludes, from his personal experience in this case, that abdominal section and washing out of the peritoneum, with subsequent drainage, is not justifiable in cases of purulent peritonitis. Last year, Dr. A. Schmidt described, in the same Russian paper, a successful case of what he considered to be laparotomy and clearing out of an intraperitoneal collection of pus; but Molodenkoff believes that an abscess in the abdominal walls only was emptied, and that the peritoneal cavity was never opened. In the *Deutshe Medicinische Zeitung*, this point is disputed. There appears, according to that journal, to have been no doubt that Dr. Schmidt opened the peritoneal cavity; but, it is pointed out, this was a case of very chronic purulent peritonitis of half a year's duration, whilst Molodenkoff's patient was suffering from an acute puerperal complication. There can be no doubt as to which proceeding was the most justifiable.—*The Brit. Medical Journal.*

On Prevention of Laceration of the Female Perinœnm.—Mr. Alexander Duke, M.K.Q.C.P.I., Obstetric Physician to Dr. Stevens' Hospital, Dublin, remarks: "The best preventive treatment of laceration that I have found (and which I dare not claim as original, though I find no notice of it in the text-books on midwifery) is this:—When I find the head fairly engaged in the pelvis, and advancing with each pain, I take my seat by the patient's bedside, and having lubricated my left thumb, or the two first fingers of my right hand, I introduce either into the vagina, and at the onset of a pain, draw back the perinæum firmly, but gently, towards the coccyz, relaxing the tension gradually as the pain lessens till the next ensues, and so on till I can draw back the perineum with very slight effort. I thus tire out the muscular structure, and produce sufficient relaxation for the head to pass.

"In most cases so treated there is no danger of the perineum, but when the pubic arch is narrow, (which can be easily determined) I take the additional precaution of raising the patient's left hip, and supporting it on a hard pillow, while the shoulders are kept low, fomenting the parts,

using inunction of lard or vaselin, and taking particular care to direct the head forward by pressure, with my left hand below the coccyx, or a finger in the rectum, leaving the perineum untouched. It has always seemed anomalous to me that the perineum should be expected to dilate on such short notice, namely, "the process of extension," while dilatation of os and cervix occupy such a considerable time, even with the additional help of nature's hydrostatic dilator, viz., the bag of waters.

"The drawing back of the perineum produces no additional pain to the patient, as it is done during an uterine contraction, and I feel sure that if nurses and students were educated as to the proper way of preparing the perineum previous to its distension with the presenting part, we should see and hear less of lacerated perineum."—*British Medical Journal.*

An Account of Two Hundred and Eight Consecutive Cases of Abdominal Section Performed Between March 1st and December 31st, 1881.—Mr. Lawson Tait, F.R.C.S., Eng., Surgeon to the Birmingham and Midland Hospital for Women, in a paper bearing this title, gives the following analysis of the series:—Exploratory Incisions, 13 cases, with no deaths; Incomplete Operations, 8 cases, with four deaths. Operations for Cystoma: One Ovary, 36 cases; Both Ovaries, 28; Parovarian Cysts, 12; Hydrosalpinx, 16; Pyosalpinx, 20; or 112 cases, 3 deaths. Removal of Uterine Appendages: for Myoma, 26 cases; for Chronic Ovaritis, 12; for Menstrual Epilepsy, 1; or 39 cases, 5 deaths. Hepatotomy for Hydatids, 2 cases; Hydatids of Peritoneum, 2; Cholecystotomy for Gallstone, 2; Radical cure of Hernia, 1; Nephrotomy for Hydatids, 1; Nephrectomy, 1; Intestinal Obstruction, 1; Solid Tumours of Ovary, 3; Hysterectomy for Myoma, 10; Cysts of unknown origin, 1; Tumours of Omentum, 1; Pelvic Abscess opened and drained, 7; Chronic Peritonitis, 4; or 35 cases, 4 deaths. Total, 208 cases, with 16 deaths. These operations were not performed under carbolic spray.—*British Medical Journal.*

M. Onimus, who is known to be one of the highest authorities on the physiological effects of electricity, has lately been studying the effects of different electrical currents on uterine action. He maintains that the unimpregnated uterus contracts but feebly under the stimulation of electrical currents, as, indeed, of other agents. In the gravid state, on the other hand, its excitability is far greater. He finds that galvanism has more effect than faradism, and that both currents act more vigorously when the uterus is spontaneously in action, a fact in entire accordance with professional opinion.—*Medical News.*

Bromide of Ethyl during Labor.—M. Lebert (*Lyon Méd.*, 1883.) who has been employing bromide of ethyl largely in midwifery cases, accords

it great value in simple confinements. It diminishes and finally suppresses the pain, without having any hurtful effect upon the mother or upon the child. He states also that under its influence labor is more rapid and surgical interference rendered less necessary. The subsequent recovery he believes to be speedier, and the tendency to flooding much less than when the drug is dispensed with.—*Glasgow Med. Journ.*, March, 1883. —*Medical Progress.*

A New Galactagogue.—According to Dr. Anderson, (*Gaz. Med. de Paris,*) nursing women in Jamaica are accustomed to drink an infusion of the leaves of *Gossyphium barbadensis.* Six or eight leaves are sufficient to make a cupful of this infusion which, when sweetened with sugar, has a very pleasant taste, may be taken to the extent of four or five teacupfuls in the day without incovenience, and invariably stimulates the flow of milk.—*Medical News.*

Pilocarpine in Puerperal Eclampsia.—P. Cantilena (*Centralb. f. klin. Med.*), reports a case in which severe eclampsia set in immediately after delivery in a woman, in whom albuminuria had been present during pregnancy. Pilocarpine was regularly administered in doses of two decigrammes two or three times daily, together with drastics, and in twenty-four hours the woman was out of danger, and a perfect cure resulted.—*Medical News.*

Porro's Operation.—Prof. Von Weber reports a case of Porro's operation (*Allgemeine Wiener Med. Zeit.*), in which he performed Porro's operation. The mother died three days after the operation; two male infants were extracted alive: of these one died two weeks later from general atrophy, while the other is still alive and vigorous.—*Medical News.*

II.—GYNECIC.

Visceral Hysteria: A brief digest of Dr. Huchard's clinical lectures at the Tenon Hospital, Paris, and published in the *Journal de Medicine et de Chirurgie Pratrique.*

If the general disturbance of the organism in somatic hysteria, as manifested by its paralysis convulsions, and its sensory and motor disorders, presents features of the deepest interest to the clinician, the study of the localized or visceral perturbations, so numerous and varied in this disease, cannot fail to prove equally interesting.

Some forms of hysteria begin purely as visceral disorders, a fact which, if not thoroughly appreciated, will often mislead the diagnostician. This

statement might be well illustrated by the history of a young girl of sixteen, in one of Dr. Huchard's wards, who, before suffering with many convulsive attacks, was troubled for months with strange phenomena about the neck of the bladder that closely simulated the symptoms of vesical calculi. Other forms of this malady, in their incipient evolution resemble the visceral lesions which are peculiar to rheumatism; they affect the internal organs for many months and years, so that they easily become the fruitful source of diagnostic errors. A patient under the care of Dr. Potain, was afflicted with a disease sufficiently obscure to lead several prominent physicians to make successively the varied diagnoses of pulmonary tuberculosis, ulcer of the stomach and tuberculous peritonitis. The last diagnosis had been made in view of the existence of the most violent abdominal symptoms, such as an intense pain and diffused tenderness, which were totally out of proportion with a very small retro-uterine hematocele that really existed. Now, it is well known that in hysterical women "great effects are often the consequence of trifling causes;" it is known that an almost inappreciable lesion engrafted upon a pre-existing hysterical state will often give rise to appearances of such great gravity that it will at times deceive the best clinicians. To illustrate these statements I need only to refer to what is so frequently observed in gynesic practice; the pelvic or ovarian congestions, so frequent among young girls, are they not often the starting points of intense abdominal pains, tympanites, vomiting, etc., etc., a group of symptoms capable of simulating a real peritonitis?

On the other hand, it must not be supposed that because of the mobility of the symptoms and the easy substitution of the phenomena that we have a sufficient proof of the neurotic origin of the malady, on the contrary, in visceral hysteria the morbid condition fixes, roots itself, so to say, in an organ with such obstinacy and tenacity that the practitioner becomes thoroughly exasperated in attempting its eradication. There are nervous coughs which persist for years; pseudo-peritonitic phenomena, which remain immovable for months, and doubtless many have noticed how long some anorexiæ will persist to some cases of scanty urine (oliguria) or suppression of urine (anuria) with uræmic vomiting occur and obstinately refuse to be corrected in spite of the most desperate therapeutic efforts. One of the characteristics of visceral hysteria is to manifest, quite frequently, a torpid, apathetic and rebellious tendency to treatment. Another peculiarity, also, is its permanent residence in an organ, without in the least affecting the organism as a whole. It is, however, a remarkable feature of this neurosis to change frequently in character without altering its seat, and it thus happens, that disorders and conditions of the most opposite nature are seen to follow closely and rapidly after each other in a single organ or viscus; that in the stomach, atonic vomiting frequently supplants spastic vomiting, and hæmatemesis

takes the place of gastrorrhea and vice-versa. The disease may be well said to become proteiform in situ.

We may ask ourselves, why is it that hysteria remains confined for such lengthy periods in the internal organs of some patients while it tends to manifest itself exteriorly or peripherically in others? Very frequently we are at a loss to explain this peculiarity. However, it has been a matter of ancient observation, that hysteria is confined to the internal organs in arthric or rheumatic subjects more often than in any other class of patients; the older writers, Whytt and Sydenham, believed that hysteria was always the offspring of rheumatism, this view, which is, of course, an exaggeration, is pressed. Again, hereditary, understood in a restricted sense may exercise a real influence upon the fixation of this neurosis in an organ or apparatus. For instance, we find that patients who are afflicted with gastric hysteria, have had gouty or rheumatic ancestors who have suffered from some disorder of the stomach, such as simple dyspepsia, gastralgia, or even, cancer of this viscus; others, again, who complain of palpitations, frequent syncopes, are the issue of mothers who have succumbed to a genuine organic heart disease; another class of patients will sometimes consult us who present the signs of a hysteroid pseudo-tuberculosis (cough, frequent hemoptysis, dyspnœa, etc.) which can be easily traced to ancestral pulmonary diseases: and, finally, is it not a matter of frequent and well attested observation that intellectual or mental hysteria has its origin in a parentage cerebrally diseased and in whose history mental alienation, mania or other affections of the nervous centers, have played a prominent part? All these facts prove, according to M. Huchard, that side by side, with the hereditary transmission of disease, we must place the peculiar hereditary disposition of the various organs, which makes each special organ or viscus the heir of the physiological or morbid peculiarities of its ancestral correlative or homologue.

After these general considerations we are ready to follow M. Huchard in his study of this neurosis as it affects the circulatory and digestive apparatus:

The circulatory apparatus is frequently the seat of trouble among hysterical subjects. In restricting myself to the cardiac phenomena it suffices to mention the frequent syncopes or lypothemiæ, the "violent pains at the heart," the truly nervous palpitations that we must learn to differentiate from a pre-existing or concomitant anæmic state, or, again, from the pseudo-palpitations induced by hyperæsthsia of the precardial wall.

Angina pectoris is comparatively rarely met with in hysteria; it was promiently noticed in 1866, by Mr. M. Friederich and Eichwald, and very recently by M. Marié, who cites two instances especially remarkable on account of the violence and intensity of the vaso-motor troubles. The intra-thoracic pains or pseudo-angina pectoris of hysterical women presents distinctive characters; its symptoms are not so pronounced; its irra-

diations are less correct, and it is much more capricious in its appearance than the classical angina-pectoris; it is frequently felt at night, and often repeats its attacks without seriously affecting the general health of the patient.

The heart is also the seat of functional murmurs which are not associated with anæmia or any other hæmic condition that might explain them. These morbid sounds appear and disappear with great rapidity and are accountable, in M. H.'s opinion, by the existence of a spasm of the papillary muscles.

At times the cardiac troubles, among which palpitations rank foremost, appear to depend on a disordered innervation of the pneumogastric nerve; for, in such cases, gastric and respiratory troubles rapidly supervene upon the cardiac phenomena. Such a pathogeny was clearly demonstrated in one of Dr. H.'s wards, by a young girl who complained of a tenderness and pain all along the course of the vagus in the neck. She has vomiting spells which are usually preceded or accompanied by the phenomena of suffocation, a croupy, spasmodic cough and palpitations, all signs which confirm once more the existence of the "morbid synergies of the pneumogastric."

Hysteria affects the stomach in various ways: *a*, through a disorder of the sensory apparatus of this organ (gastralgia, painful vomiting from gastric hyperæsthesia, vomiting without straining efforts and due to gastric anæsthesia), *b*, through a disorder of its motor nerves (spasmodic gastralgia, spastic vomiting (?) pylorismus (spasm of the pylorus), gastric atony and transitory dilatations of the stomach); *c*, through secretory and glandular disturbances (flatulence, aqueous vomiting from grastrorrhœa, uræmic vomiting from vicious or vicarious excretion, etc.). Again we not unfrequently meet, among hysterical subjects, with a hysterical pseudo-gastralgia, in which the pain, instead of being situated in the viscus, is only a superficial tenderness or pain over the epigastric region.

It is also important, according to M. Huchard, to differentiate between the various forms of hysterical vomiting, the latter term being too broad, according to this teacher, to cover up the diverse conditions which underlie the pathology of vomiting in hysteria. This differentiation should not be made for the sake of diagnostic accuracy alone, but as a matter of decided importance in practice:

1st. Vomiting due to hyperesthesia or to spasm of the stomach, follows shortly after taking meals. The vomiting spells are frequent, painful, accompanied by nausea and frequently followed by diarrhœa. In either case (whether vomiting be due to hyperesthsia or spasm), opiates before meals (morphia, hypodermically administered) and hot fomentations over the epigastric wall should be resorted to. If pharyngeal hyperesthesia is superadded to increased sensitiveness of the gastric wall, inhalation of a

concentrated solution of potassium bromide, directed to the pharyngeal wall with the atomizer, is indicated and should be used.

2d. In another class of cases, vomiting comes on tardily, long after the ingestion of food, without nausea or pains; it is associated with a distention of the stomach and constipation. It is the vomiting dependent upon gastric atony for its causation. In these cases, opiates are contra-indicated and should not be administered. Stomachics or carminative stimulants, bitters, nux vomica, strychnia, and even faradization of the epigastrium are the remedial agents to be used.

3. Vomiting due to a disturbance of the secretory apparatus of the stomach, such as gastrorrhœa, etc., is manifested by the very profuse emesis of an aqueous or mucous fluid during or after the meals. It is in this trouble that frequent washing of the stomach should be resorted to.

4th. Gastrorrhagic vomiting is often the most rebellious of all these various hysterical disorders. Whenever bloody vomiting is supplementary or vicarious to suppressed or diminished menses, the action of the remedies should be directed to the re-establishment of the catamenial flow; in the opposite instance, when the hematemesic spells are due to a vaso-motor trouble (?) in the gastric mucous membrane, then vaso-constrictor remedies, such as ergot, or ergotine, the perchloride of iron and quinine, are indicated. Derivative medication will also frequently meet with success; dry cups, blisters and touching the epigastrium with a thermo-cautery are thus recommendable.

4th. At times the vomiting spells are preceded or accompanied by cough, dyspnœa, palpitation and pain along the vagus in the neck, such cases are properly classified as instances of neuralgia of the pneumogastric nerve (pneumogastralgia). In such cases the repeated application of the constant current will prove beneficial.

6th. Finally, another class of cases in which a vomiting takes place, that is characterized by the discharge of a fluid containing urea, and by its occurring in conjunction with the phenomena of anuria or oliguria. These are improperly designated as cases of "uremic vomiting," though they are in reality never accompanied by the toxic phenomena of uremia. They rather represent a supplementary or vicarious vomiting of the renal excreta, strictly comparable to the vicarious vomiting of blood in amenorrhœa. In these patients we frequently have an opportunity to observe the symptams which M. Fabrel (of Marseilles), has appropriately classified as "suspensive" or "inhibitory" hysteria. In this condition the nutritive processes seem totally suspended, and assimilation and disassimilation arrested. This general nutritive inhibition seems to predominate throughout the glandular system, but is especially noticeable in the secretory apparatus of the stomach, which seems totally paralyzed; the patients eat no more, they cease to urinate, and, notwithstanding all this, manage to maintain their natural "embonpoint." There is a suspension of

the absorbent functions and elimination is arrested, so that all medicines taken exhibit none of their physiological properties; the patient is plunged in the therapeutic ataxia or apathy which hysterical subjects not infrequently exhibit. In these conditions of glandular inactivity, the food introduced into the stomach amounts to just so much foreign material introduced into this organ. Of course it is promptly rejected and thrown up, just as would happen in a case of indigestion from an overloaded stomach.

This so-called uremic vomiting is no more allied to a disorder of the stomach than is the supplemetary vomiting of blood in the vicarious hematemesis of amenorrhœa; the functional trouble lies not in the stomach but in the kidneys; therapeutics has nothing to do with the stomach, it has all to do with the disordered kidneys. Unfortunately, however, it is just in such a case that the therapeutist is totally disarmed; here, the practitioner can achieve nothing by the administration of medicines, for the economy remains totally indifferent to the absorbtion of aliments and medicines in virtue, purely, of this *salutary* perversion or suspension of nutrition. Notwithstanding this discouraging knowledge of the impotence of the materia medica, these very cases are the ones that furnish the material for celebrated cures; singular, unexpected and almost extraordinary recoveries may result from a sudden strong emotion, by fear, hope or an absolute, blind faith in a physician or his medicines,—we thus understand the modest but at times miraculous virtues of the unofficinial pilula micæ panis.

In all cases of visceral hysteria hydrotherapy is the most important mode of practice. But the douche should not be prescribed blindly and carelessly, as is usually done, for if the stream of water be directed too strongly against painful or histero-genetic spots we will only succeed in exasperating the patient and aggravating the morbid condition.

In treating hysterical vomiting dependant upon spasm of the stomach and especially of its cardiac or esophageal portion, the introduction of foods through an alimentary tube (Faucher's) will often succeed when all other measures will fail.

Such are the principal facts discussed by the distinguished physician of the "Hospital Tenon;" they amply demonstrate the importance that should be attached to the study of visceral hysteria whether we consider it from either the diagnostic, prognostic or therapeutical standpoint.—*New Orleans Medical and Surgical Journal.*

Improved Method of Treating Uterine Displacements.—By Robert Bell M. D., in (*Edinburgh Med. Journ.*) The peculiar poising of the uterus in the body, the elasticity, or rather yielding nature of its supports, and its dependence upon the health of the neighboring viscera for this support being uniformly maintained, renders it peculiarly liable to displacement.

Anything which interferes with the health of the womb, and will thus render it more susceptible of disease, and will predispose to malposition. If constipation exists, then the weight of the feces in the sigmoid flexure and the higher reaches of the colon will not only interfere with the free circulation in the pelvis, but also by mechanical pressure on the organ crowd it out of position. If we have an irritable bladder, and in consequence the viscus being unable to retain more than a few drachms of urine, the straining which accompanies micturition will force the uterus forwards. Another pregnant cause of displacement is dyspepsia, which causing distention of the intestinal canal, brings undue pressure to bear from above upon the fundus. One more powerful factor has recently been pointed out, viz., the endeavor to obtain greater compass and volume in singing by powerful action of the abdominal muscles, and so forcing downwards all the viscera. It is obvious that any causes such as those enumerated must be removed before local remedies can have the desired effect. It will also be necessary to attend to the health of the canal of the neck and body of the organ at the time the displacement is being tackled, or we will be most certainly disappointed.

I have had this remedy as it now stands in use about two years, and have treated over 200 cases during the 18 months. Every form and gradation of displacement has come under observation, and in every case great relief was obtained, and in the majority of cases complete cure was the result. The patient requires to be under careful and patient observation for weeks in every case, and in many instances for months at a time; but surely these are trifling objections. I had used, for years previously, the ordinary glycerine of tannin of the pharmacopœia; but though I found it a most efficacious astringent, yet its expense and the disadvantage of staining the underclothing told very much against it. Had recourse to the following:—Glycerine, 80 oz,; alum, 10 oz.; carbolic acid, 1¼ oz. If a displacement continues for any length of time, hypertrophy of some portion or of the whole organ is the result. We have thus a greater strain thrown upon the uterine supports, so that what at one time was a stay becomes a factor in aggravating the disease. Our first duty, then, is to endeavor to reduce the overgrowth, and at the same time prevent its recurrence by rectifying the position of the organ and retaining it *in situ*. When we have a hyertrophied condition of the walls of the uterus, in the majority of instances there is softening of the texture, so that a flabby condition results. In these cases it is a matter of little difficulty to restore the position of the organ, but as soon as the support is removed it falls back into its abnormal position. Moreover if there exists, (which frequently does), any amount of inflammatory action, the presence of a pessary is a most serious source of danger; and besides suffering supposing there is no danger of an attack of acute metritis, there yet remains the disadvantage that the relief is entirely due to the fact that a mechanical

support is being retained in the vagina, and which every little while requires to be removed to make way for one of larger size, till in the course of a short time the walls of the vagina become as capacious as the pelvis will admit of; moreover the woman always retains the disagreeable consciousness that she is wearing an instrument, and there is ever present the danger of the hard pessary injuring the soft parts upon which it is constantly resting. A pessary to be of service must fit accurately, and only long experience and patient care will ensure this result. If it does not apply itself with precision to the parts, it certainly will result in serious mischief. One advantage of my treatment is, that it is rarely necessary to employ either probe or elevator when there is a flexion. This is another prolific source of danger removed.

Prolapse of the uterus: This may vary from a slight lowering of the position of the womb to complete procidentia. It is due either to (1) an increase in weight of the organ; (2) to faulty action of the supports; (3) it may arise from pressure from above, or from all these factors combined.

A lacerated perinæum must of course be rectified before treatment. From whatever cause prolapse occurs, there is always, as a result, hypertrophy of the organ and relaxation of the vaginal walls and uterine ligaments. If the uterus, then, is elevated to its normal position, and retained there by a suitable appliance, the hypertrophy will disappear, and if at the same time we can stimulate the capillary circulation of the parts, and also cause a steady drain to take place of the watery constituents of the blood in the uterus and its neighborhood, we will do much to remove the tendency to the displacement by reducing the size of cotton saturated with the glycerine of alum and carbolic acid, and allowing this to remain in the vagina from 3 to 4 days. The tampon excites an abundant watery discharge from the vagina, necessitating the patient constantly to wear a napkin. Glycerine excites this discharge, but when combined with an astringent, the effect is an even more profuse drainage of the watery components of the blood; the effect on the capillary circulation is also intensified, and the astringent effect on the vaginal wall is most beneficial. By this means alone I have completely cured procidentia which existed 3 to 8 years, after above treatment had been persevered in for from 2 to 7 months, and in a few cases where the disease existed for a much greater time very great relief has been experienced after more protracted treatment. If the tampon is merely saturated with glycerine it becomes very offensive after a few hours; when, however, the carbolic acid is added, there is no fetor at the end of four days when the tampon may be replaced. We can keep the organ *in situ* for months, and likewise act on it and the neighboring tissues to restore them to a healthy condition, the woman's general condition indicating a marked improvement. I claim for this method of treatment equal advantages with any plastic operation that may be performed upon the vaginal wall; and there is this, that the uterus

itself also probably partakes of benefits which an operation on the vaginal walls cannot confer.

Versions and flexions of the uterus: I have treated quite a number of cases which had been subjected to the general routine of pessaries and stems without deriving any benefit whatever, and which have, after a few applications of the tampon, expressed themselves as feeling great relief. It may perhaps be interesting to give one case. This lady had been suffering from retroflexion of the uterus for six years, which was aggravated very much by obstinate constipation, but this symptom had been quite overlooked. She was a most miserable looking object, with an ashy complexion, which, however, was partly attributable to the absorption of fetid matter from fæcal accumulations in the rectum and colon, as when these masses were removed and kept from accumulating, her complexion improved, and she felt somewhat relieved in every way. Yet the least exertion completely prostrated her, and the dysmenorrhœa was most intense. For six years she had been under treatment by means of pessaries and stems of all descriptions from solid silver stems down to pessaries made of gutta-percha covering copper wire, and with no benefit; in fact, she was daily getting worse. In this case I used *two* tampons saturated with the solution, one much smaller than the other, so that it would occupy a position supporting the fundus, well up in Douglas' pouch, while the other and larger tampon was placed behind the cervix, and acted as a support to the smaller. After three months she was able to endure considerable fatigue, and eat and digest satisfactorily, and sleep well, feats she could not perform before; and at this moment I know she enjoys life thoroughly.

I think it often a good plan to employ two tampons in retroflexion and also in anteflexion, but, as a rule, one answers all the purpose. It is gratifying to observe the speedy effect of this treatment on the bladder symptoms in anteversion and anteflexion. I think I need hardly enter into further details as to the method of treating other varieties of displacements.—*The Canada Lancet.*

Application of the Speculum.—M. Fournier, in *L'Union Méd.*, recommends in vaginal examinations with the bivalve speculum, that the instrument should be slightly tilted so that the upper valve should rest firmly upon the anterior lip of the cervix, then by slowly opening the instrumen t the anterior lip is raised and the cervical cavity is disclosed to view, permitting a more thorough and useful examination.

Treatment of Exophthalmic Goitre by Subcutaneous Injections of Duboisia.—M. Desnos reports three cases of exophthalmic goitre treated by a daily subcutaneous injection of from one-half to one milligramme of neutral sulphate of duboisia. In all three cases the improvement was mark-

ed: there was diminution in the projection of the eye, and in palpitation; improvement of the general health, and reduction in the pulsation and murmur in the thyroid gland. When the treatment was discontinued the improvement disappeared. Further observations are necessary to determine whether a permanent cure may be produced by means of this drug. In two cases there were slight symptoms of the physiological action of the drug.—*L'Abeille Med.*, Feb. 5, 1883.

III.—DISEASES OF CHILDREN.

A Pupillary Phenomenon Observed in Certain Morbid Conditions in Childhood.—Dr. Parrot records in the *Revue de Médicine* for October, 1882, a number of observations made by him in regard to a reflex dilatation of the pupil, occurring in certain pathological conditions in young children. In these affections, dependent or not upon evident lesions of the nervous centres, accompanied or not by convulsions, but always by coma, if the skin of the epigastrium, or of any other part of the body be pinched, there follows a momentary dilatation of the pupil. Among the affections in which this phenomenon is observed are tubercular meningitis, hemorrhage beneath the pia mater, some cases of chronic hydrocephalus, and certain other undefined conditions in which the contents of the cranium are increased out of proportion to its capacity. In other comatose conditions, usually without convulsions, there is no response of the pupils to even violent pinching of the integument. In these cases there may be œdema or marked congestion of the pia mater, but the factor of cerebral compression is absent. From his present observations the author is unable to determine the precise diagnostic or prognostic value of this phenomenon, but he formulates one conclusion, viz.: In a child in a comatose condition, whether there be convulsions or not, if the pupils do not respond to peripheral irritation in the manner indicated, we can exclude meningitis and hemorrhage beneath the pia mater—the child is suffering from asphyxia and his death is imminent.—*New York Med. Record.*

The Contagion of Measles.—Dr. A. Beclére (*Gaz. Med. de Paris*) has made a careful study of the conditions attending the contagion of measles, of which we select his more important conclusions.

Rubeola is contagious from the commencement of the period of invasion to the end of the stage of eruption, a period extending through from eight to ten days. The contagious principle is contained in the secretion of the respiratory mucous membrane, and it still remains to be proved that it has anything to do with the cutaneous desquamation. Although

this contagion is diffusible, it is so only to a slight extent, and soon looses its active properties, and does not remain in the rooms occupied by the sick. The period of incubation lasts from thirteen to fifteen days; no immunity is conferred by the presence of any other eruptive disease.—*Medical News.*

Whooping-Cough.—M. Dujardin-Beaumetz gives a table or a dessert-spoonful, according to the age of the child, of the following mixture in whooping-cough, night and morning:—Bromide of potassium, 30 grains; bromide of sodium, 60 grain; bromide of ammonium, 30 grain; chloral, 20 grains; water, 4 oz.

Gossip.

THE following incident happened in the court-room of Binghamton, and will interest all students of comparative anatomy:—The case in point was this:—Mr. A. sold a colt, as a gelding, to Mr. B., which colt had had but one testicle removed, the other remaining within the cavity of the abdomen. The veterinary surgeon who had castrated the animal was sworn, and, on his cross examination, stated the following interesting features in the anatomy of the horse:—

Attorney.—What are the varicose veins and where are they found?

Witness.—I don't know, but I can tell where the bellicose veins are.

Attorney.—Where are they?

Witness.—Close to the belly.

Attorney.—Where is the scrotum?

Witness.—I am not quite certain, but I think that it is the film than covers teeth during infancy.

Attorney.—Have you ever made any examinations in the abdominal region?

Witness.—No; all of my examininations have been made in Broome County.

Attorney.—That is sufficient.—*The Proceedings.*

AUNT BETSY'S 'SIMPSONS."—The following is a perfectly probable if not verbatim report of an old negro woman's enumeration of her woes:

"My mis'ry, doctor, wuks right up from bofe my legs, an' up frough my stummick, an' den crost my bow'ls, all a shaky an' a wigwaggy! Den my right shoulder, doctor. *Law Sakes!!!* Dat yer mis'ry in my right shoulder pow'ful bad sometimes. Den I has shootin' pains all up an' down de spine uv my back, dreafful! an' lumps in my flanks, an a burnin' all over my right side, an' a roarin'! yes, honey, a awful roarin' in my head, an de bones all loose in my head. Den I has pains in bofe shoulders, an' my insides dey workin' jes' like maggots!! an' I has a draggin' in my stummich, an' my sistum very bad. Ef you b'lieve me, doctor, dar's a patch of mis'ry in de small o' my back, an' when I stan' up 'pears like my insides dey stickin' to my spine! an' a wall'win' in my haid, an' I done got no appetite ter eat, an' pears like every minit I gwine frow up my insides. I cain't drink no fresh

water; drinks all my water *biled!* In de night you can hear my head a roarin' an' a bussin', an' den my bowels gits to wukin', an' you kin hear 'em a crackin' an' a trimblin'. Den I has a hotness in de bone o' my neck; yes, doctor, right in de bone o' my neck, an' at fuss a *pang* riz right up acrost my neck, an' riz an' *bust!!!* I knowed it wa'nt a blood-wessel, else I'd a-died *sho!*"—*Louisville Medical News.*

WANTED HIM TO TAKE MORE EXERCISE.—Scene: Office of a pompous doctor who knows it all. Enter a tired man who drops into a seat, and says that he wants treatment. The doctor puts on his eye glasses, looks at his tongue, feels his pulse, sounds his chest, and then draws up to his full height, and says "Same old story, my friends. Men can't live without fresh air. No use trying it. I could make myself a corpse, like you are doing by degrees, if I sat down in my office and did'nt stir. You must have fresh air; you must take long walks, and brace up by staying out doors. Now I could make a drug store of you, and you would think I was a smart man, but my advice to you is to walk, walk, walk."

Patient.—But, Doctor———

Doctor.—That's right. Argue the question. That's my reward. Of course you know all about my business. Now, will you take my advice? Take long walks every day, several times a day, and get your blood in circulation.

Patient.—I do walk, Doctor. I———

Doctor.—Of course you do walk. I know that; but walk more. Walk ten times as much as you do now. That will cure you.

Patient.—But my business———

Doctor.—Of course, your business prevents it. Change your business, so that you will have to walk more. What is your business?

Patient.—I am a letter-carrier.

Doctor (paralyzed)—My friend, permit me to once more examine your tongue.—*The Proceedings.*

INFANT OVARIOTOMY.—Dr. Hingston, of Montreal, recently removed an ovarian tumor from a child two years of age. The patient was doing well at last account.—*Canada Lancet.*

ROMAN CATHOLIC DOCTORS.—Catholic Priests are amongst the most faithful and devoted of our professional friends. Some time ago a litttle chick complained that she did'nt have a—*Roman Catholic Doctor*,—and why says the anxious mother.—Why, the Roman Catholic Doctors don't give *strong medicine.*—Well, when we came to understand her trouble, she wanted—Lord Forgive as a—*Homeopathic!* that was her understanding of a "*Roman Catholic Doctor.*"

AN extraordinary security was offered by a man who recently advertised in a Berlin newspaper for a loan. The advertisement ran as follows:—"A medical student whose means are exhausted would like to meet with some one who would advance him the necessary sum to complete his studies, at a moderate rate of interest. If necessary he would as a guarantee at once marry his creditor's daughter, or, if he prefers it, would give an undertaking to do so on passing his final examination."—*Medical and Surgical Reporter.*

THE LITTLE BARE BABY.—The story that a baby has been somewhere born with an elephant's head has reached Derby, where a lady asked her physician if he thought it possible. "Why, certainly," replied the doctor, "know myself of the

case in my own practice of a bare baby that has been recently born to a very worthy couple in this town." "Is that so?" said the lady, "and is it alive?" "Oh, yes, and doing well." A few days after this, having told the story to all her friends the lady met the doctor again and inquired how the bare baby was getting along. "Oh, first rate," said he, "but it was not more bare than all babies." The lady saw the point, colored red beautifully, and threatened to "get even" with the physician, which the Sentinel says she will too, if the doctor does'nt look out for himself.

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This handsome volume opens the series of Wood's Library of Standard Authors for 1883. The style of binding and general appearance of the book is very elegant, and will add to the appearnance of the doctor's library. A second volume is to follow completing the entire work of Drs. Hart and Barbour. The present volume considers: The Anatomy and Physiology of the Pelvic Organs; Physical Examination of the Female Pelvic Organs; Diseases of the Pelvic Organs; *Fallopian Tubes and Ovaries; Affections of the Uterus.* The illustration are very excellent, and the consideration of the topics thus far makes this a very desirable addition to Gynecological literature.

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